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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on March 23-25, 2022 and March 28, 2022. The investigation was reopened with an onsite investigation on 04/11/22-04/12/22.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure referral and follow up for 2 of 2 sampled residents (#1, #4) as evidenced by failure to notify the Endocrinologist of a diet order change from a no concentrated sweet to a regular diet for a resident with diabetes (#1); and a referral for a resident with orders for physical therapy and occupational therapy (#4). The findings are: 1. Review of Resident #1's current FL-2 dated 03/02/22 revealed: -Diagnoses included type 2 diabetes, unspecified dementia, bi-polar disorder and essential hypertension. -Resident #1 was intermittently disorientated and resided on the Special Care Unit (SCU). -The diet order was no concentrated sweets (NCS). Review of the dietary Order Report by Category, containing a listing of residents' diets dated 02/23/22 - 03/23/22 revealed: -There was a NCS order from the previous	D 273		

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Primary Care Provider (PCP) for Resident #1 with a start date of 09/11/21.
-There was a stop date of 03/18/22 documented beside the start date.
-There was a strike through across the NCS diet documentation indicating the previous PCP's NCS diet order for Resident #1 dated 09/11/21 had been stopped.

Observation of the lunch meal on 03/23/22 at 12:05pm for Resident #1 revealed the resident was served green beans, 7 small breaded shrimp, a bowl of mayonnaise based coleslaw and 3 hushpuppies with unsweetened tea.

Interview with Resident #1 on 03/23/22 at 12:06pm revealed:
-She had diabetes and was supposed to be given an NCS diet to help keep her blood sugar level from getting too high.
-She was not served NCS meals, so she tried to be careful in choosing what foods she ate at mealtime.
-She was told by the kitchen staff the facility only offered a Regular diet and not the NCS diet.
-Her Endocrinologist (physician specialist for the management and treatment of diabetes) ordered she have a NCS diet.

Interview with a SCU personal care aide (PCA) on 03/23/22 at 9:05am revealed:
-She assisted residents with personal care, passing out snacks and residents' plates at meals.
-Snacks consisted of cheese crackers, peanut crackers, potato chips, baked cookies and a double chocolate cookie with filling in between.
-Residents with diabetes were served the same snacks as other residents.
-Resident #1 was given 3 scheduled snacks a

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day but she would usually came back asking for 2 more snacks to keep in her nightstand beside her bed.
-Resident #1's family also brought cookies and crackers for her to have in her room.
-She was not sure what type of diet Resident #1 was ordered.

Interview with the Head Cook (HC) on 03/23/22 at 10:05am revealed:
-The corporate office did not authorize the facility to offer a NCS diet for residents with diabetes.
-There was no Registered Dietician planned NCS diet on their meal planning spreadsheet.
-There was a NCS guideline sheet posted on the kitchen bulletin board to use for reference in serving residents with orders for NCS diets.
-The facility only offered regular or regular with texture modifications like mechanical soft or chopped meats.
-Resident #1's NCS diet order (09/11/21) was discontinued when the new PCP signed an order for a regular diet for Resident #1 on 03/18/22.

Interview with the contracted Registered Dietitian (RD) on 03/23/22 at 4:58pm revealed:
-There had not been any changes in the facility's decision to not offer the NCS diet to residents.
-She knew of no changes coming up for the diets at the facility.
-The diets, according to corporate management, were to remain regular with the options of mechanical soft or chopped meats.
-She did not offer any suggestions for options for diets other than regular mechanical soft or with chopped meats.
-The facility referred to recommendations for foods for residents with diabetes obtained from the American Diabetes Association (ADA) reference materials.

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Interview with a SCU medication aide (MA) on 03/24/22 at 9:50 am revealed:
-She did not know why Resident #1's diet was changed from NCS to Regular.
-A resident on a Regular diet could eat anything they wanted but a resident on a NCS diet could not have foods with sugar.
-Resident #1 received snacks 3 times a day and often wanted more.
-Resident #1's finger stick blood sugar (FSBS) readings went up and down depending on what she had eaten that day.

Interview with Resident #1 on 03/24/22 at 9:27am revealed:
-Her Endocrinologist managed her diabetes medications and ordered a NCS diet for her to eat because her blood sugar was too high.
-When she ate a Regular diet her FSBS rose to around 300.
-She was aware of some foods she should not eat and often she would tell dietary staff to give her a substitute food.
-The facility did not offer her a NCS diet and her Endocrinologist wrote an order for her to have the NCS diet.
-When her FSBS was high she would be concerned about having diabetes affecting the health of her heart.
-She thought having high FSBS had already affected her eyesight; sometimes she did not see very clearly.

Interview with the Special Care Coordinator (SCC) on 03/23/22 at 4:00pm revealed:
-She would be sent changes of diet orders from physicians and document the orders on the Order Report by Category.
-Resident #1's previous PCP ordered a NCS diet

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for Resident #1 on 09/10/21 and was documented on the Order Report by Category.
-The new PCP ordered a NCS diet for Resident #1 on the FL-2 dated 03/02/22.
-The NCS diet was not a diet offered by the facility for residents because the corporate office only offered regular diets for the residents residing in their facilities.
-The SCC sent the new PCP the list of diets offered by the facility (regular, regular with mechanical soft texture and regular with chopped meats).
-The new PCP changed Resident #1's diet to regular on 03/15/22.
-The change was to clarify what diet the PCP wanted for Resident #1.
-She did not know if the new PCP was aware Resident #1 had an Endocrinologist managing Resident #1's diabetes.
-The change of diet order request was not sent to Resident #1's Endocrinologist.
-She had not called or spoken with Resident #1's Endocrinologist.
-The facility's practice was to contact the PCP when they had changes in residents' orders.
-The Power of Attorney (POA) for Resident #1 would be the person to notify the Endocrinologist of the change in diet from NCS to Regular.
-There was no system in place to call providers other than the residents' PCP for clarification of orders.

Attempted telephone interview with the SCC on 04/11/22 at 8:06am was unsuccessful.

Telephone interview with the resident care coordinator (RCC) on 04/11/22 at 8:58am revealed:
-There was a 'bucket" system for physician orders that needed processing or clarification, one to

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make calls to the PCP to reconcile the orders and the other to wait until the PCP returned to the facility to review.
-No specialists were called, she waited to speak with the PCP if residents' orders did not match.
-Some residents had more than one health care provider but there was no system in place to routinely communicate with the other providers.
-Resident #1's Endocrinologist would not have been called to clarify a diet order or to notify a diet order had been changed; she would check with the PCP for the latest order.
-She had not been in contact with Resident #1's Endocrinologist about the resident's diet orders.

Telephone interview with Resident #1's POA on 03/23/22 at 11:56am revealed:
-She was notified of Resident #1's change of diet from NCS to regular by the PCP on 03/15/22.
-She would never approve for Resident #1 to have a regular versus an NCS diet.
-A NCS diet would help in the management of Resident #1's diabetes.
-The Endocrinologist wrote orders for Resident #1 to have an NCS diet continuously.
-She spoke to the Administrator several times about offering an NCS diet for Resident #1; she visited the resident very frequently and spoke to the Administrator during the visits.
-The facility admitted Resident #1 knowing she had a physician's order for an NCS diet.

Review of Resident #1's Endocrinologist's order dated 03/14/22 for "Diet: no concentrated sweets" with the notation to fax (the facility) with the fax number included.

Telephone interview with Resident #1's PCP on 03/24/22 at 12:03pm revealed:
-She first visited Resident #1 on 02/14/22 and

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signed a new FL-2 for the resident on 03/02/21.
-She was aware of the previous PCP's order dated 09/11/21 for a NCS diet for Resident #1 and she continued the order on the new FL-2 document.
-She was contacted by the SCC on 03/02/21 to complete an additional Physician Order Report to change the diet order from NCS to regular because the facility did not offer an NCS diet.
-She and Resident #1's endocrinologist had the same patient data system and were able to read each others' progress notes for Resident #1.
-She concurred with the Endocrinologist's observations that Resident #1 could suffer elevated blood glucose levels affecting her heart, kidneys and eyes and Resident #1 needed to eat a NCS diet which was ordered on Resident #1's FL-2 dated 03/02/22.
-On 03/15/22 she was told by the SCC she needed to change the diet order for Resident #1 to regular since they did not offer the NCS diet for Resident #1.
-She had a discussion with the Administrator about offering an NCS diet for Resident #1, but the discussion was unsupportive of the NCS diet and she was requested to order the regular diet for Resident #1.
-She signed an order for a regular diet for Resident #1 on 03/18/22.

Second telephone interview with the current PCP on 04/12/22 at 10:38am revealed:
-She established care for Resident #1 on 02/14/22.
-The NCS diet for Resident #1 had been an on-going problem.
-She completed and signed the FL-2 on 03/02/22 with NCS diet ordered.
-The POA informed her that Resident #1 was on NCS diet.

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D 273	Continued From page 7 -She was able to look in the computerized health system and read the Endocrinologist reports since they belonged to the same health system. -She saw where the Endocrinologist also wanted Resident #1 on a NCS diet. -The facility notified the PCP the week of 03/16/22 to "correct" paperwork; the correction they asked was to change the diet to regular. -The SCC informed the PCP that the facility did not offer a NCS diet. -She signed the diet order on 03/15/22 for a regular diet; however, the date on the diet order had been changed to 03/18/22. -She did not know who changed the diet order dated from 03/15/22 to 03/18/22. -She attempted to speak to the Administrator and the SCC on 03/18/22 by phone but was unsuccessful. -She did speak to the Resident Care Coordinator (RCC) who verified that the facility did not offer a NCS diet and the PCP would need to speak to the POA. -The facility staff had not contacted her about new diet orders from the Endocrinologist; she received her information from Resident #1's daughter or the computerized health system. -She did not manage Resident #1's diabetic medications; the Endocrinologist managed the diabetic medications. -She had never spoken with the Endocrinologist; she could if she needed too; she read the Endocrinologist notes in the health system. Telephone interview with the Endocrinologist on 03/23/22 at 10:51am revealed: -The Endocrinologist had managed Resident #1's type 2 diabetes since October 2021. -The NCS diet was the best plan to help lower Resident #1's blood sugar and prevent damage to her organs.	D 273		

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-After the previous PCP's order on 09/18/21 for continuous NCS diet, she sent an order on 02/28/22 for a NCS diet for Resident #1 and another on 03/14/22 to continue the NCS after being told by the resident's POA the facility was not serving the NCS diet as ordered.
-The orders were given to the POA and faxed to the facility on the dates of the orders.
-She was never notified by the SCC if the NCS orders were received.
-She never received communication from the facility about Resident #1.
-According to the POA, Resident #1 was not receiving the NCS diet when the POA visited the resident at the facility.
-She had the same patient data system as the PCP and they were able to read each others progress notes for Resident #1.
-Resident #1's Hemoglobin A1c (blood test for type 2 diabetes indicating control of sugar levels) was 10 on 10/12/21 and 8.4 on 02/02/22; the preferred range for people with diabetes was around 7.
-If Resident #1's FSBS were 200 or higher, Resident #1 could suffer long term damage to her kidneys, heart and eyes.
-She never discontinued the orders for a NCS diet for Resident #1.

Second telephone interview with the Endocrinologist on 04/12/22 at 3:00pm revealed:
-She established services with Resident #1 in October of 2021.
-She did not know the PCP had ordered a regular diet
-She did not know the facility did not offer a NCS diet.
-She did not know why the facility would not offer a NCS diet.
-She had not been in contact with the PCP; she

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had no reason to contact her.
-She could look in the health system and read the PCP's clinical notes.
-The PCP could see the Endocrinologist clinical notes and the Endocrinologist could see the PCP's clinical notes
-She faxed an order for a NCS diet on 03/14/22.
-The facility did not notify her that they did not offer a NCS diet.
-Resident #1 needed a NCS diet.
-The POA informed the Endocrinologist the facility was not following the NCS diet as ordered.
-A NCS diet would help Resident #1 lower her blood sugar.
-She thought Resident #1 was having some issues with her eyes, but she could not be sure.
-She received most of Resident #1's information from the POA, which was not unusual for a resident who resided in an assisted living facility.
-She expected the facility to notify her if they could not provide what was ordered.

Review of Resident #1's February 2022 medication administration record (MAR) revealed:
-There was an entry to check FSBS 3 times a day before meals.
-There were 24 FSBS readings over 200 and ranging from 203-309 from 02/01/22 to 02/28/22.

Review of Resident #1's March 2022 medication administration record (MAR) revealed:
-There was an entry to check FSBS 3 times a day before meals.
-There were 38 FSBS having readings over 200 and ranging from 201-332 from 03/01/22 to 03/22/22.

Interview with the Administrator on 03/24/22 at 2:05 pm revealed:
-She was aware of the requests for the NCS diet

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D 273	Continued From page 10 for Resident #1. -She told the PCP the facility did not offer the NCS diet. -She offered Resident #1 unsweetened tea and desserts having no sugar. -She did not contact Resident #1's endocrinologist about the NCS diet and did not know what they would want to know. -The PCP was the contact they used for clarifying resident's orders. -She did not know if any orders were received from the endocrinologist for Resident #1 and did not know if any were sent. -The SCC handled residents' orders. -The PCP signed the order request for a Regular diet for Resident #1. Second interview with the Administrator on 04/11/22 at 1:46pm and 2:26pm revealed: -The SCC notified the PCP regarding the NCS diet order on the FL-2 dated 03/02/22. -The PCP was notified by the SCC of the diets and textures of diets that were offered since the facility did not offer a NCS diet. -The SCC should have documented in the progress notes the communication with the PCP. -The goal was to get a diet order the facility served. -Resident #1 was offered unsweet tea and sugar-free desserts upon her request. -The PCP asked that the facility and the POA work together to provide Resident #1 with a suitable diet. -She had spoken with the POA and informed her that the facility did not offer NCS diet. -The POA's request was that the facility would offer Resident #1 NCS diet. -She informed the POA the facility could continue to offer Resident #1 unsweet tea and sugar free desserts as requested.	D 273		

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-The POA's response was Resident #1 needed a NCS diet and she wanted her to have it.
-She had not reached out to the Endocrinologist; she did not know if the SCC had notified the Endocrinologist regarding the NCS diet.
-The SCC received the incoming orders; she would process them and contact the PCP or endocrinologist when needed.

Interview with the Regional Director of Clinical Services (RDCS) on 04/11/22 at 1:46pm revealed:
-The facility did not offer a no concentrated sweet diet (NCS).
-It was a corporate policy that a NCS diet would not be offered.
-The facility offered a Regular, no added table salt (NATS) diet with texture options.
-There were no other diet options offered at the facility.
-The facility had a pre-printed diet order sheet.
-The PCP would check the diet and the texture, if needed.
-The PCP would sign and date the diet order form.
-She reached out to the previous PCP in January 2022; Resident #1 has a different PCP now.
-The previous PCP was informed that the facility did not offer a NCS diet.
-The response from the PCP's office on 01/19/22 was "Resident #1 needed as close to an ADA diet as possible.
-Resident #1 had changed PCPs twice since January 2022.
-The previous diet order on the FL-2 signed by the current PCP, dated 03/02/22, was NCS.
-The SCC notified the current PCP and obtained an order for a Regular diet; the diet order was signed on 03/18/22.
-Resident #1 was admitted to the facility in July

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2021.
-There was an order on her FL-2 for a NCS diet on admission.
-The facility did not notice the NCS diet order until October 2021.
-The corporation had over 100 facilities across 5 states and a NCS diet was not offered at any of the facilities.
2. Review of Resident #4's FL-2 dated 02/23/22 revealed:
-Diagnoses included dementia with behavioral disturbances, diabetes mellitus 2, hypertension, congestive heart failure and anxiety.
-Resident #4 was ambulatory with a walker.

Review of Resident #4's physician's visit summary dated 03/03/22 revealed:
-Resident #4's gait was unstable.
-Resident #4's should continue using a walker for mobility.
-The staff should monitor Resident #4 closely for falls.
-The staff should assist with activities of daily living as needed.

Review of Resident #4's physician's orders dated 03/03/22 revealed there was an order for physical therapy (PT) and occupational therapy (OT) for gait instability.

Interview with the Primary Care Provider (PCP) on 03/28/22 at 11:59am revealed:
-Resident #4 had fallen on the day she was admitted to the facility, 03/02/22.
-Resident #4 requested to have PT and OT related to her fall and use of a walker.
-She ordered PT and OT to evaluate Resident #4 on 03/03/22.
-She faxed the electronic order to the facility.
-The facility was responsible for sending the

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referral to the therapy department.

Interview with Resident #4 on 03/24/22 at 10:05am revealed;
-She fell the day she was admitted.
-She had requested PT and OT after she fell.
-She had not received PT and OT since admission.
-She did not know why therapy had not been started.

Review of Resident #4's record revealed there were no PT or OT notes available for review.

Interview with Special Care Coordinator (SCC) on 03/24/22 at 11:30am revealed she did not know Resident #4 had a referral for PT and OT.

Telephone interview with the Rehabilitation Director for the facility's contracted rehabilitation agency on 03/28/22 at 12:26pm revealed:
-He was in the facility three days a week to provide physical therapy services.
-The SCC would hand him new orders for residents when he was in the facility.
-The SCC would call the agency and fax new orders to the office if he was not in the facility when the order came in.
-He had not received an order for PT and OT for Resident #4.
-He had not provided therapy services to Resident #4.

Telephone interview with the Area Manager for the facility's contracted rehabilitation agency on 03/28/22 at 1:29pm revealed:
-The rehabilitation agency had not started PT or OT for Resident #4.
-The rehabilitation agency received a referral today, 03/28/22, for Resident #4's PT and OT.

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D 273	Continued From page 14 -The facility would give new orders to the rehab director for the facility when he was in the facility or the order would be faxed to the agency office. Telephone interview with the Administrator on 03/28/22 at 11:05am revealed: -The SCC was responsible for contacting outside agencies when referrals were ordered for PT and OT. -She was not familiar with the process of how referrals where delivered to outside agencies. -She had only been acting Administrator less than 2 months. -She knew the facility had a contract with an outside therapy department to provide PT and OT to the residents. Attempted telephone interview with the SCC on 03/28/22 at 8:16 was unsuccessful.	D 273		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure therapeutic diets were served as ordered for 3 of 3 sampled residents (Residents #10, #11, #12) with an	D 310		

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order for a pureed diet (#12); a mechanical soft diet (#10); and a chopped meat diet (#11).

The findings are:

1. Review of Resident #12's current FL-2 dated 02/22/22 revealed diagnoses included dementia, iron deficiency, and anemia.

Review of Resident #12's facility's diet order form dated 03/22/22 revealed:
-Diet type was a regular diet.
-Diet consistency was a pureed diet.
-A Pureed diet was defined as a diet that provided foods of a smooth, soft consistency, like fluffy whipped potatoes.
-Pureed foods were usually ordered for residents with difficulty swallowing.
-The modification could be limited to a portion of the meal, such as meats only or the entire meal.

Review of the diet order spread sheet dated 02/23/2022-03/23/2022 revealed Resident #12's diet order was pureed meal.

Review of a large whiteboard across from the meal prep area in the kitchen on 03/25/22 at 10:22am revealed:
-Resident #12's was listed as pureed.
-There was an 8 x 10 piece of paper taped to the bottom right hand of the whiteboard that had Resident #12 listed as chopped meat only.

Observation of the lunch meal service on 03/23/22 at 12:13pm revealed Resident #12 was served a pureed meal; she ate 100%.

Observation of the dinner meal service on 03/23/22 at 4:48pm revealed:
-Resident #12 was served a chicken sandwich

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(filet on a bun) cut into fourths.
-Resident #12 ate 1/2 of the sandwich.
-Resident #12 was served whole mixed vegetables (cauliflower, carrots, and broccoli) and she ate the carrots and broccoli.
-Resident #12 was served and ate 1/2 cup of potato salad.
-Resident #12 was served and ate 3 ounces of fruit cocktail.

Interview with a personal care aide (PCA) on 03/23/22 at 12:28pm revealed:
-Resident #12's diet was changed to pureed 2 days ago.
-Resident #12's teeth were breaking, and it was hard for her to chew her food.
-Resident #12 would take about an hour to eat regular food.

Interviews with another PCA on 03/25/22 at 2:35pm and 4:39pm revealed:
-She assisted with feeding Resident #12 when she worked.
-Resident #12 was served a chicken sandwich, mixed vegetables, and potato salad on 03/23/22.
-Resident #12 did not appear to have any problems with chewing or swallowing.
-She did not know Resident #12 was on a pureed diet.
-The dietary staff would tell the PCAs when a diet change was made.

Interview with a medication aide (MA) on 03/25/22 at 2:43pm revealed:
-Resident #12 was pocketing food in her jaw, especially meat, when eating a regular diet.
-She knew Resident #12 was on a pureed diet.
-She informed the PCAs of diet changes as soon as she was made aware of the diet change.
-All staff needed to be informed of Resident #12's

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diet change so they could make sure the resident received the correct diet.

Interview with the Special Care Coordinator (SCC) on 03/25/22 at 2:47pm revealed:
-Resident #12 had been pocketing food in her cheeks.
-The SCC spoke with the Primary Care Provider (PCP) regarding changing Resident #12's diet to pureed.
-The PCP wrote an order for Resident #12 to be served a pureed diet on 03/22/22.
-The PCP made a copy of the diet order and gave it to the dietary manager.
-The PCAs and MAs were notified of the diet change for Resident #12 by word of mouth.
-It was not documented anywhere for the MAs and PCAs to refer to.
-The PCAs and MAs should have notified the dietary staff when Resident #12 received the incorrect diet.

Interview with the Administrator on 03/25/22 at 2:57pm.
-If Resident #12 was on a pureed diet, there was a reason.
-Resident #12 could choke if she was given the wrong diet consistency if she was having problems with swallowing or chewing.
-She would need to clarify why Resident #12 was on a pureed diet, if it was because of chewing or swallowing.

Telephone interview with Resident #12's PCP on 03/29/22 at 12:45pm revealed:
-Resident #12's diet was changed to pureed to see if it would improve the resident's appetite and she would eat more.
-She was not sure if Resident #12 was having chewing issues, but it was easier to try a texture

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change to see if it made a difference versus having to have a speech therapy consult.
-She expected Resident #12's meals to be served pureed for every meal so she would know if the change was effective or not.

Based on observations, record reviews, and interviews, it was determined Resident #12 was not interviewable.

Refer to the interview with the Administrator on 03/25/22 at 2:57pm.

2. Review of Resident #10's current FL-2 dated 03/22/22 revealed:
-Diagnoses included dementia and unspecified protein-calorie malnutrition.
-She was intermittently confused, and the recommended level of care was a special care unit.

Review of Resident #10's facility's diet order form dated 03/22/22 revealed:
-Diet type was a regular diet.
-Mechanical soft was defined as a diet modification for residents who had difficulty chewing but were able to tolerate more texture than a pureed diet offered.
-The modification could be limited to a portion of the meal, such as meats only or the entire meal.
-The entire meal was marked for Resident #10.

Review of the diet order spread sheet dated 02/23/2022-03/23/2022 revealed Resident #10's diet order as a mechanical soft diet (entire meal).

Review of a large whiteboard across from the meal prep area in the kitchen on 03/25/22 at 10:22am revealed:
-There was documentation two residents in the

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D 310	Continued From page 19 special care unit (SCU) were on mechanical soft diets; Resident #10's name was not listed. -There was an 8 x 10 piece of paper taped to the bottom right hand of the whiteboard that had Resident #10 listed as a mechanical soft. Observation of the lunch meal service on 03/23/222 at 12:13pm revealed: -Resident #10 was served a whole piece of fish, three plain hushpuppies, coleslaw, and green beans. -Resident #10 ate 50% of her fish, two of the three hushpuppies, ¼ of her coleslaw, and 100% of the green beans. Observation of the dinner meal service on 03/23/22 at 4:48pm revealed: -Resident #10 was served a chicken sandwich (chicken patty between two buns), mixed vegetables, and fruit cocktail. -Resident #10 ate ½ of her chicken patty and ½ of one part of the bun. -Resident #10 ate 100% of her mixed vegetables and fruit cocktail. Review of the therapeutic menu spreadsheet for a mechanical soft meal for fish, hushpuppies, chicken, and coleslaw revealed: -The fish should be soft, and bite-sized. -The hushpuppies should be moistened. -Coleslaw should be substituted with minced and moist vegetables. -Chicken sandwiches should be ground meat. Telephone interview with Resident #10's primary care provider (PCP) on 03/28/22 at 12:45pm revealed: -Resident #10 was admitted with failure to thrive. -Resident #10 was on a mechanical soft diet and was doing well.	D 310		

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D 310	Continued From page 20 -If Resident #10 was not served a mechanical soft diet, she would be concerned the resident may not eat as well and would therefore have weight loss. -She expected Resident #10 to be given food that was easy for her to eat and get the best nutrition she could. -If Resident #10 did not eat it would lead to other issues. Telephone interview with the facility's contracted registered dietitian on 03/25/22 at 10:02am revealed: -Fish should be soft and cut into bite-sized pieces that would be easy to chew and swallow. -Hushpuppies should be moistened, with a sauce or even with ketchup. -A sauce was to help the hushpuppies go down easier and keep the resident safe. -Coleslaw was a raw vegetable and raw vegetables were harder to swallow and needed to be replaced with soft, cooked vegetables. -She expected the dietary staff to follow the directions for therapeutic diets. Interview with the Dietary Manager (DM) on 03/25/22 at 2:03pm revealed: -A mechanical soft diet meant the food needed to be a "little softer." -Resident #10 was on a chopped diet. -Resident #10's fish was soft, and she could cut it herself easily. -She did not know Resident #10 was also on a mechanical soft diet. -She did not know why Resident #10 was on a mechanical soft diet. Interview with the Special Care Coordinator (SCC) on 03/25/22 at 2:11pm revealed: -Diet order changes were given to the DM and	D 310		

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were changed in the computer system.
-For a mechanical soft diet, she expected the meat to be chopped when it left the kitchen.
-She did not know coleslaw was not to be served on a mechanical soft diet.
-She thought hushpuppies were okay to be served as long as they had been cooked soft.
-She expected the medication aides (MA) to walk around the dining room to ensure plates were correct.
-The MAs were responsible for notifying the personal care aides (PCA) if a resident had a diet other than a regular diet.
-She was concerned the staff were not paying attention and put the residents at risk of a choking hazard.

Interview with a MA on 03/25/22 at 2:43pm revealed:
-She thought Resident #10 was on a regular diet.
-Resident #10 had been having a hard time swallowing.
-She had not seen the order for Resident #10 to have a mechanical soft diet.
-If she had seen Resident #10's order for a mechanical soft diet she would have made sure Resident #10 was served the correct diet.
-She was responsible for telling the PCA of changes in diet orders.
-She had not told the PCAs Resident #10's diet had changed because she did not know.
-She thought there needed to be more communication about diet orders.

Interview with the Administrator on 03/25/22 at 2:57pm revealed:
-Resident #10's fish should have been chopped when the plate was served.
-Resident #10 should not have been served coleslaw but substituted with soft cooked

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vegetables.
-She was not sure how hushpuppies should be served but would expect them to be served as directed on the therapeutic diet spreadsheet.

Based on observations, record reviews, and interviews, it was determined Resident #10 was not interviewable.

Refer to the interview with the Administrator on 03/25/22 at 2:57pm.

3. Review of Resident #11's current FL-2 dated 02/23/22 revealed:
-Diagnoses included dementia, glaucoma, deconditioning, and Vitamin D deficiency.
-She was constantly disoriented and required assistance with feeding.

Review of Resident #11's facility's diet order form dated 03/22/22 revealed:
-Diet type was marked for no added table salt.
-Mechanical soft was defined as a diet modification for residents who had difficulty chewing but were able to tolerate more texture than a pureed diet offered.
-The modification could be limited to a portion of the meal, such as meats only or the entire meal.
-The chopped meats only was marked for Resident #11.

Review of the diet order sheet dated 02/23/2022-03/23/2022 revealed Resident #11's diet order as a mechanical soft diet (chopped meats only).

Review of a large whiteboard across from the meal prep area in the kitchen on 03/25/22 at 10:22am revealed:
-There was documentation two residents in the

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assisted living were on chopped diets.
-Resident #11's name was not listed.
-There was an 8 x 10 piece of paper taped to the bottom right hand of the whiteboard that had Resident #11 listed as chopped meat only.

Observation of the lunch meal service on 03/23/222 at 12:14pm revealed:
-Resident #11 was served a bowl of fried shrimp, coleslaw, hushpuppies, and green beans.
-Resident #11 ate 50% of her shrimp, one of the four hushpuppies, 50% of her coleslaw, and 50% of the green beans.

Observation of the dinner meal service on 03/23/22 at 5:13pm revealed:
-Resident #11 was served a whole chicken sandwich (chicken patty between two buns), mixed vegetables, and potato salad.
-The personal care aide (PCA) handed the plate back to the dietary staff and said, "this needs to be chopped."
-Resident #11's plate was returned to her with the chicken sandwich cut into 4 pieces.
-Resident #11 was holding one of the four pieces of chicken sandwich, taking smile bites.

Review of the therapeutic menu spreadsheet for a mechanical soft meal chopped meats only revealed:
-Shrimp was not listed on the spreadsheet for guidance on how to serve.
-Coleslaw should be substituted with minced and moist vegetables.
-Chicken should be chopped.

Telephone interview with the facility's contracted registered dietitian on 03/25/22 at 10:02am revealed:
-If the facility did not have a spreadsheet to use

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for guidance for shrimp, then the shrimp should not be served to anyone on a therapeutic diet.
-Without a spreadsheet for guidance, the dietary staff would not know how to serve shrimp on a chopped meat diet.
-Shrimp would need to be chopped and moistened for anyone on a chopped meat diet.
-If a sandwich was cut into fourths that would be considered finger food, not chopped.
-Resident #11's chicken sandwich should have been cut into small bite-size pieces.

Interview with a personal care aide (PCA) on 03/25/22 at 11:10am revealed:
-Resident #11 was on a chopped meat-only diet.
-She was not sure why Resident #11 was on a chopped meat diet.
-She knew Resident #11 could not chew lettuce but was not aware of any other issues.
-Resident #11 had been on a chopped meat diet since admission.
-The dietary manager notified her of any diet changes.
-She thought Resident #11's shrimp was small enough; she did not know it needed to be chopped.
-She did not know Resident #11's chicken sandwich needed to be cut into smaller pieces.

Interview with the Administrator on 03/25/22 at 2:57pm revealed:
-Resident #11's chicken should have been chopped and then placed on the bun.
-She was not sure what needed to be done with Resident #11's shrimp.

Based on observations, record reviews, and interviews, it was determined Resident #11 was not interviewable.

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D 310	Continued From page 25 Attempted telephone interview with Resident #11's primary care provider on 03/25/22 at 3:12pm was unsuccessful. Refer to the interview with the Administrator on 03/25/22 at 2:57pm. ________________________ Interview with the Administrator on 03/25/22 at 2:57pm revealed: -The SCC/RCC and the DM were provided copies of new diet orders. -The SCC/RCC and the DM should update their diet list and provide the correct diets. -The SCC/RCC were responsible for updating the MAs and PCAs on diet changes. -Residents were on a therapeutic diet for a reason, whether it was because of chewing or for swallowing -She expected meals to be served as ordered and the diet order clarified if they were not sure.	D 310		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO UNABATED TYPE B VIOLATION Non-compliance continues with increased	D 358		

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severity resulting in residents placed at substantial risk that serious physical harm will occur.

TYPE A2 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 7 residents (#6, #7) observed during the morning medication pass including errors with the administration of a pain medication (#6) and a medication for memory loss (#7); and for 6 of 7 sampled residents for record review including errors with a medication used to prevent seizures (#2); insulin administration (#3); an inhaler, and medications for mood disorders (#5); three supplements (#4); an anti-depressant and a medication for reflux (#6); and a stool softener, a pain medication and a medication used to treat manic episodes (#8).

The findings are:

1. The medication error rate was 11.5% as evidenced by the observation of 3 errors out of 26 opportunities during the 8:00am and 5:00pm medication pass on 03/23/22.

a. Review of Resident #6's FL-2 dated 02/21/22 revealed:
-Diagnoses included Alzheimer's disease and dementia.
-There was an order for etodolac (used for arthritic pain) 400mg twice a day.

Review of Resident #6's physician's orders dated 03/07/22 revealed:
-There was an order to discontinue etodolac 400mg twice a day.
-There was an order for etodolac 400mg as

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needed for pain and discomfort.

Observation of the morning medication pass on 03/23/22 at 8:08am revealed:
-The medication aide (MA) removed Resident #6's 8:00am multi-dose pack from the drawer of the medication cart.
-The multi-dose pack contained 7 pills; the name of each medication was listed on the multi-dose pack.
-Etodolac 400mg was 1 of 7 medications listed as being in the multi-dose pack.
-The number "7" was on the multi-dose pack indicating the number of pills that was in the pack.
-The MA administered the 7 pills to Resident #6, including etodolac 400mg.

Review of Resident #6's March 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for etodolac 400mg with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation etodolac 400mg was administered twice a day from 03/01/22 to 03/24/22 at 8:00am and 8:00pm.

Observation of Resident #6's medication on hand on 03/23/22 at 10:44am revealed there was a multi-dose pack with etodolac 400mg available for administration at 8:00am and 8:00pm.

Based on eMAR documentation, medication dispensing records and medications on hand it was determined that Resident #6 was administered 34 doses of etodolac 400mg after the medication had been discontinued.

Telephone Interview with a pharmacy technician from the facility's contracted pharmacy on

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03/24/22 at 8:36am revealed:
-The pharmacy had an order for etodolac 400mg twice a day dated 08/07/21.
-The order dated 08/07/21 was the last order received for etodolac.
-The pharmacy did not receive a signed physician's order dated 03/07/22 to change etodolac from twice a day to as needed for pain and discomfort.

Telephone Interview with the Pharmacist from the facility's contracted pharmacy on 03/25/22 at 8:13am revealed:
-Etodolac was used for myalgia or arthritic pain.
-Potential side effects could be gastro-intestinal bleeding, abdominal pain, diarrhea and nausea if a resident was administered medication more than prescribed.

Interview with the MA on 03/24/22 at 10:18am revealed:
-The MA administered etodolac 400mg 11 times from 03/07/22 to 03/24/22.
-The MA administered etodolac 400mg twice a day because it was on the eMAR and in the multi-dose pack to administer.
-The MA did not know the etodolac 400mg had been changed from twice a day to as needed.
-The MA was not responsible for discontinuing or adding medications on the eMAR.
-The Special Care Coordinator (SCC) was responsible for e-faxing new or changed orders to the pharmacy.
-The pharmacy would enter the new orders into the eMAR and the change would appear on the eMAR.
-The MA had no way of knowing the etodolac order had changed unless it was entered onto the eMAR.

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D 358	Continued From page 29 Interview with a second MA on 03/24/22 at 4:10pm revealed: -The MA administered etodolac 400mg twice a day since it was on the eMAR and in the multi-dose packs. -The MA had administered etodolac 400mg 4 times from 03/07/22 to 03/24/22. -The MA did not know the etodolac 400mg had been changed from twice a day to as needed. -The MA administered the medication as directed on the eMAR. -The MA would not know a medication was changed unless it was entered on the eMAR. -The SCC e-faxed new orders to the pharmacy. -The pharmacy would enter changes to the medications on the eMAR. Interview with the SCC on 03/24/22 at 10:15am revealed: -She e-faxed new orders to the pharmacy when they were written. -She would call the pharmacy to verify they received the e-faxed orders, when scheduling permitted. -She had e-faxed the physician's orders dated 03/07/22 to the pharmacy. -She could not remember the first time she e-faxed the physician's order dated 03/07/22, but she e-faxed it again today, 03/24/22, because the pharmacy staff called and said they did not have it. -She did not call the pharmacy today to see if they had received the e-faxed physician's order dated 03/07/22 for Resident #6. -The pharmacy should enter the order into the eMAR when it was received. -She informed the MA about the new medication order and instructed the MA to make a notation on Resident #6's multi-dose pack	D 358		

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Telephone interview with a nurse at Resident #6's Primary Care Provider's (PCP) office on 03/26/22 at 11:42am revealed:
-Resident #6 was receiving etodolac for pain.
-The PCP talked with Resident #6's family member and discussed decreasing her medication from twice a day to as needed.
-The family member agreed with the medication changes.
-The PCP expected all orders to be followed as ordered.

Telephone interview with the Administrator on 03/28/22 at 9:29am revealed:
-New orders should be e-faxed to the pharmacy when the order was received.
-The SCC was responsible for e-faxing new orders to the pharmacy.
-She did not know if Resident #6's order had been faxed to the pharmacy.
-She expected new orders to be faxed to the pharmacy as soon as possible.
-The pharmacy would enter the new orders into the eMAR and they would be approved by the SCC.

Attempted telephone interview with Resident #6's PCP on 03/25/22 at 10:09 was unsuccessful.

Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable.

b. Review of Resident #7's FL-2 dated 03/15/22 revealed:
-Diagnoses included dementia with Lewy body, visual hallucinations, fatigue, insomnia and anxiety disorder.
-There was an order for donepezil (used to slow down memory loss and improve cognitive

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function) 10mg at bedtime.

Observation of the morning medication pass on 03/23/22 at 8:14am revealed:
-The medication aide (MA) removed the 8:00am multi-dose pack for Resident #7 from the drawer of the medication cart.
-The multi-dose pack contained 7 pills; the name of each medication was listed on the multi-dose pack.
-Donepezil 10mg was 1 of 7 medications listed as being in the multi-dose pack.
The number "7" was on the multi-dose pack indicating the number of pills that were in the pack.
-The MA administered the 7 pills to Resident #6, including donepezil 10mg.

Review of Resident #7's March 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for donepezil 10mg with a scheduled administration time of 8:00pm.
-There was documentation donepezil 10mg was administered at bedtime from 03/01/22 to 03/15/22 at 8:00pm.
-There was an electronic entry that donepezil 10mg was discontinued on 03/16/22.
-There was a second entry on 03/15/22 for donepezil 10mg before bedtime with a scheduled administration time of 5:00pm.
-There was documentation donepezil 10mg was administered before bedtime from 03/16/22 to 03/22/22 at 5:00pm.
-There was no entry for donepezil 10mg to be administered at 8:00am.
-There was no documentation of donepezil 10mg administered during the 8:00am medication pass on 03/23/22 at 8:14am.
-The MA documented that 6 medications were

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administered on 03/23/22 at 8:00am.

Observation of Resident #7's medications on hand on 03/23/22 at 10:50am revealed:
-There was a bubble pack with 8 donepezil 10mg tablets on hand; the pharmacy label read administer one tablet every evening before bed.
-The bubble pack of donepezil 10mg was dispensed on 03/16/22.
-There was a morning multi-dose pack available for administration; the multi-dose pack contained 1 donepezil 10mg.
-There was no medication bottle of donepezil 10mg available for administration.

Based on eMAR documentation, medication dispensing records and interviews it was determined that Resident #6 was administered 22 doses of donepezil 10mg at 8:00am from 03/01/22 to 03/24/22.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 03/24/22 at 8:36am revealed:
-The pharmacy had a physician's order on file for donepezil 10mg every morning dated 07/31/21.
-The donepezil 10mg tablet was packed in the multi-dose pack since 07/31/21.
-The donepezil 10mg was placed in the multi-dose pack to be administered in the morning at the 8:00am medication pass.
-On 03/16/22 the pharmacy received an FL-2 dated 03/15/22 with an order for donepezil 10mg at bedtime.
-The pharmacy dispensed 9 tablets of donepezil 10mg on 03/16/22 to be administered until the medication was placed in the cycle filled multi-dose pack for bedtime.
-The facility staff should remove donepezil 10mg from the morning multi-dose pack and administer

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D 358	Continued From page 33 donepezil 10mg from the bubble pack that was dispensed on 03/16/22 until donepezil 10 mg was placed in the multi-dose pack for bedtime. Interview with the MA on 03/24/22 at 10:18am revealed: -The MA signed Resident #7's eMAR for all medications administered on 03/23/22 at the 8:00am medication pass. -The MA administered 7 pills to Resident #7 on 03/23/22 at the 8:00am medication pass. -The MA thought she had documented 7 medications were administered at 8:00am on 03/23/22. -The MA checked the eMAR with the medications in the multi-dose pack and checked "prep" on the eMAR. -After she administered the medications, she returned to the eMAR and checked "complete", which would electronically document her initials on the eMAR. -The electronic documentation would only be entered in the medications that were checked prep. -The MA did not realize donepezil 10mg was in the morning multi- dose pack. -The MA did not notice the donepezil when she compared the multi-dose pack with the eMAR. -The MA needed to speak to the SCC about the error. -Resident #7 could receive too much medication if the donepezil was in the morning dose and it was administered as scheduled in the evening. c. Observation of the Special Care Coordinator (SCC) on 03/23/22 at 4:20pm during the 5:00pm medication pass revealed: -The SCC prepared donepezil 10mg for administration for the 5:00pm administration from a bubble pack.	D 358		

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D 358	Continued From page 34 -The SCC approached Resident #7 to administer the donepezil 10mg. -The SCC was stopped by the surveyor informed of the donepezil 10mg in the morning multi-dose pack. -The SCC destroyed the donepezil 10mg she had prepared. Interview with the SCC on 03/23/22 at 4:22pm revealed: -The SCC did not know donepezil 10mg was in the morning multi-dose pack. -The entry for donepezil 10mg was on the eMAR for 8:00pm administration until orders received on 03/15/22 for the medication to be administered at bedtime and the time was changed to 5:00pm. -The SCC did not know why it was scheduled at 5:00pm since the order was written for bedtime. -The pharmacy sent 9 tablets of donepezil 10mg on 03/16/22 to be used for the evening dose until the medication was placed in the evening multi-dose pack. -Resident #7 could have received too much medication if she had administered the donepezil 10mg. -The SCC expected the MAs administering the morning medications to have noticed the donepezil 10mg in the morning multi-dose pack and it was scheduled for 8:00pm. Interview with second a MA on 03/24/22 at 4:10pm revealed: -The MA worked second shift. -The MA documented 6 out of 23 opportunities in March of 2022 that she administered donepezil 10mg at 8:00pm. -The MA administered donepezil as ordered and as entered in the eMAR. -Resident #7 had a bottle of donepezil 10mg available to administer.	D 358		

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-The MA administered donepezil 10mg from the bottle of medication that was available.
-The MA did not know the donepezil was dispensed in the multi-dose pack for 8:00am.

Interview with the SCC on 03/25/22 at 11:05am revealed:
-The MAs needed to read the eMAR and compare each medication in the multi-dose pack with the medication entered on the eMAR.
-If the donepezil was not on the eMAR to be administered at 8:00am, it should have been pulled from the multi-dose pack and destroyed.
-The SCC had not noticed the donepezil was in the multi-dose pack for administration at 8:00am and entered on the eMAR for administration at 8:00pm.
-The SCC would have expected this to be caught with the medication cart audit.
-The MAs did the cart audits every week.
-The SCC would assign a different MA to complete the medication cart each week.

Telephone interview with the nurse from Resident #7's PCP office on 03/25/22 at 11:55am revealed the medication was ordered because of Resident #7's diagnosis of dementia.

Telephone interview with the Administrator on 03/28/22 at 9:29am revealed:
-The Administrator expected the MA to compare the entry in the eMAR with the medications on hand three times before administration.
-The MA did not verify each medication in the multi-dose pack with the eMAR.
-Had the MA verified the medication with the eMAR she would not have administered the donepezil 10mg with the morning medication pass.
-There was an opportunity for Resident #7 to

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receive donepezil twice a day if the MAs did not remove the donepezil from the morning multi-dose pack.

Refer to the telephone interview with a pharmacy technician from the facility's contracted pharmacy on 03/24/22 at 8:36am.

Refer to the interview with the Special Care Coordinator (SCC) on 03/24/22 at 10:15am.

Refer to the interview with the Administrator on 03/28/22 at 9:29am.

2. Review of Resident #2's current FL-2 dated 02/17/22 revealed:
-Diagnoses included seizure disorder, hypertension, heart failure, dementia, and a history of cerebral aneurysm.
-There was an order for Depakote 500mg every 12 hours. (Depakote is used to treat seizure disorders).

Review of Resident #2's hospital visit summary dated 02/18/22 revealed:
-Resident #2 was seen in the emergency department secondary to a seizure and a fall.
-Resident #2's Depakote level was below therapeutic level (38). (The therapeutic range for Depakote is 50-100 mcg/mL).
-There was an order to increase Resident #2's evening Depakote dosage to 750mg and repeat labs in one week.

Review of Resident #2's primary care provider's (PCP) after visit summary dated 02/24/22 revealed:
-Resident #2 was seen for a follow-up to a recent seizure with a fall and emergency department evaluation on 02/18/22.

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-Resident #2's Depakote level was 94.1 on labs dated 02/22/22. (Toxicity may occur at levels >100).
-Plan was to stop Resident #2's Depakote 250mg at bedtime and start ½ tablet of Depakote 250mg (total 125mg) at bedtime.

Review of Resident #2's PCP after visit summary dated 03/10/22 revealed:
-The visit was to follow up on the recent titration of Depakote following ER visit for an acute seizure.
-Resident #2's Depakote level was 54.6 on labs dated 03/04/22.
-Resident #2's Depakote level was borderline low with a therapeutic range of 50-100.
-Plan was to stop Resident #2's ½ tablet of Depakote 250mg (125mg) and start Depakote 250mg give one tablet daily in between the Depakote 500mg every 12 hours.
-There was documentation Resident #2's seizure disorder was chronic and poorly controlled.
-Referral made to have Resident #2 see Neurology for evaluation of seizure disorder.

Review of Resident #2's Neurology after visit summary dated 03/15/22 revealed:
-Instructions were to continue Resident #2's current Depakote regimen of Depakote 750mg in the morning, 250mg in the afternoon, and 500mg plus an additional 125mg at bedtime.
-Referral was made for an electroencephalogram (EEG) to evaluate seizures on 03/31/22 at 3:00pm. (An EEG is used to record the electrical activity of the brain.)
Review of Resident #2's February 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Depakote 500mg every 12 hours with a scheduled administration time of

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D 358	Continued From page 38 8:00am and 8:00pm. -There was documentation Depakote 500mg was administered at 8:00am and 8:00pm from 02/01/22-02/28/22. -There was an entry for Depakote 250mg with a scheduled administration time of 8:00pm. -There was documentation Depakote 250mg was administered at 8:00pm from 02/19/22-02/27/22. -There was an entry for Depakote 250mg administer ½ tablet in addition to the 500mg with a scheduled administration time of 8:00pm. -There was documentation ½ tablet of Depakote 250mg was administered at 8:00pm on 02/28/22. -Resident #2's Depakote 250mg was administered 4 times after it had been discontinued by Resident #2's PCP and Resident #2's Depakote 125mg was not started for 4 days after the order was changed. Review of Resident #2's March 2022 eMAR revealed: -There was an entry for Depakote 500mg every 12 hours with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Depakote 500mg was administered at 8:00am and 8:00pm from 03/01/22-03/08/22. -There was a second entry for Depakote 500mg every 12 hours with a scheduled administration time of 7:00am and 7:00pm. -There was documentation Depakote 500mg was administered at 7:00am and 7:00pm from 03/09/22-03/14/22 and at 7:00am on 03/15/22. -There was a third entry for Depakote 500mg every 12 hours with a scheduled administration time of 7:00am and 7:00pm. -There was documentation Depakote 500mg was administered at 7:00am and 7:00pm from 03/17/22-03/24/22. -There was no documentation Resident #2 was	D 358		

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D 358	Continued From page 39 administered his 500mg pm dose on 03/15/22 and there was no documentation Depakote 500mg was administered on 03/16/22. -There was an entry for Depakote 250mg administer 1 tablet daily with a scheduled administration time of 8:00am. -There was no documentation Depakote 250mg was administered at 8:00am; an exception was documented on 03/11/22 that it had been discontinued. -There was an entry for Depakote 250mg administer ½ tablet at bedtime in addition to the bedtime 500mg dose with a scheduled administration time of 8:00pm. -Depakote 250mg (1/2 tablet) 125mg was documented as administered at 8:00pm from 03/01/22-03/08/22. -There was a second entry for Depakote 250mg administer ½ tablet at bedtime in addition to the bedtime 500mg dose with a scheduled administration time of 7:00pm. -Depakote 250mg (1/2 tablet) 125mg was documented as administered at 7:00pm from 03/09/22-03/17/22. -There was an entry for Depakote 250mg take 1 tablet every day in between the 500mg doses with a scheduled administration time of 2:00pm. -Depakote 250mg was documented as administered at 2:00pm on 03/11/22 and from 03/13/22-03/16/22. -There was an exception documented on 03/12/22 as duplicate order. -There was a second entry for Depakote 250mg take 1 tablet every day in between the 500mg doses with a scheduled administration time of 1:00pm. -Depakote 250mg was documented as administered at 1:00pm on 03/12/22 and 03/13/22; an exception was documented on 03/14/22 as a duplicate order.	D 358		

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Based on review of Resident #2's March 2022 eMAR Depakote 125mg was administered 7 times at bedtime after the order had been stopped and Depakote 250mg was administered twice on 03/13/22 when the order was for once a day.

Observation of Resident #2's medications on hand on 03/24/22 at 11:36am revealed:
-There was a multidose package labeled 03/24/22 for morning medications, afternoon medications, and bedtime medications.
-The morning medication package labeled 03/24/22 contained Depakote 500mg.
-The afternoon medication package labeled 03/24/22 contained Depakote 250mg.
-The evening medication package labeled 03/24/22 contained Depakote 500mg.

Telephone interview with a pharmacy technician on 03/24/22 at 1:04pm revealed:
-Resident #2's original order dated 01/14/22 was for Depakote 500mg every twelve hours and a 7-day supply was dispensed.
-A 28-day supply of Depakote 500mg was dispensed on 01/21/22 and 02/18/22 and a 7- day supply was dispensed on 03/15/22.
-On 02/18/22, fourteen tablets of Depakote 250mg were dispensed with the directions to administer at bedtime in addition to the 500mg.
-On 02/26/22, a new order was received for Depakote 250mg give ½ tablet at bedtime in addition to the 500mg and six doses of Depakote 125mg was dispensed.
-On 03/04/22 an additional six doses of Depakote 125mg were dispensed.
-On 03/11/22, six doses of Depakote 250mg were dispensed with instructions to administer midday.
-On 03/15/22, seven doses of Depakote 250mg

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were dispensed.
-Resident #2's multidose packages were now dispensed every 7-days and contained Resident #2's Depakote 500mg twice a day and Depakote 250mg once daily.

Telephone interview with a nurse at Resident #2's Neurologist office on 03/25/22 at 8:17am revealed:
-Resident #2 was seen by the Neurologist on 03/15/22.
-Resident #2's eMARs were provided to the Neurologist on the day of the appointment.
-The Neurologist wanted Resident #2 to continue taking the Depakote 750mg in the morning, 250mg midday, and 500mg plus 125mg at bedtime.
-The Depakote dosage was obtained off Resident #2's eMARs.
-Resident #2's Depakote level had been really low on the visit to the emergency department on 02/18/22 and the Neurologist thought the amount listed on Resident #2's eMAR was the dosage Resident #2 was being administered.
-If Resident #2 was not taking "that much" he may need to be taking more and would need another Depakote level drawn to determine how much Depakote needed to be administered to maintain a therapeutic range.
-No one had called to clarify the order or to notify them Resident #2 was not taking the Depakote as the Neurologist had ordered to be continued.

Telephone interview with Resident #2's PCP on 03/25/22 at 9:15am revealed:
-She had not seen Resident #2's visit summary from the Neurologist.
-The facility staff had asked her multiple times to clarify Resident #2's Depakote order when she added in the 250mg midday.

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-She did not understand what had been confusing about the Depakote order for Resident #2 and was concerned the medication had not been administered correctly.
-She was making medication adjustments based on her assuming the orders had been changed and administered correctly with each change.
-She needed to have an accurate reflection of the dosages of Depakote that had been administered to Resident #2 to determine how to titrate the medication.
-If Resident #2's Depakote was not administered correctly and she was not aware, she was making unnecessary changes and ordering unnecessary tests.
-If Resident #2's Depakote was not titrated appropriately the resident's Depakote level could become toxic if the Depakote level was too high or he could have seizures if the Depakote level was too low.

Interview with Resident #2 on 03/25/22 at 9:48am revealed:
-He had a seizure when he lived at "the other place" but when he had a seizure "last month" that was the first one since moving to this facility.
-He saw the Neurologist "about a week ago."
-The Neurologist said since he was doing okay that he would leave his medication like it was but may need to increase it later.
-The Neurologist did not say why he may need to increase the medication later.

Interview with a medication aide (MA) on 03/25/22 at 10:59am revealed:
-New orders were given to the Resident Care Coordinator (RCC) either directly or scanned into the computer if the RCC was not working and then she would notify the RCC the orders had been scanned in.

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-Resident #2's Depakote order had changed but she was not sure of the changes.
-She administered medication based on what the current order was in the eMAR.
-She did not recall any details about Resident #2's Depakote other than she administered the Depakote that was in the multidose package each morning.

Interview with the RCC on 03/25/22 at 3:23pm revealed:
-She was the RCC but was working as the MA today, 03/25/22.
-She was responsible for processing all orders for the assisted living residents.
-The pharmacy staff entered orders into the eMAR and the orders were then reviewed and accepted by the RCC or the Special Care Coordinator (SCC).
-When medications were delivered, they were compared to the resident's eMAR to ensure they matched before the medication was put on the medication cart.
-She did not know why Resident #2's Depakote had been administered incorrectly.
-She thought the MAs were not paying attention.
-She recalled there had been some confusion with the ½ tablet of Depakote but did not recall the details.
-She did not know why there were multiple entries of Depakote on Resident #2's eMAR.
-When Resident #2 had changes in his Depakote, the changes should have been made immediately.
-If Depakote 250mg was stopped at bedtime, it should have been stopped the same day the order was received
-If the Depakote 125mg was stopped at bedtime, it should have been stopped the same day the order was received.

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D 358	Continued From page 44 -She usually made rounds with the PCP or they would leave new orders and she would review the orders and scan them to the pharmacy. -She expected the MAs to read the order on the eMAR, compare it to the medication to be administered and if there was something they were not sure about, ask for clarification. -After Resident #2 saw the Neurologist there were no changes in the Depakote order; she read the order and the order said to keep the same doses. -She did not realize the dosage the Neurologist had documented was different than the Depakote that was being administered. -She should have compared the Neurologist note to Resident #2's current orders. -She was concerned Resident #2 was not getting his Depakote administered correctly and put him at risk of having seizures. Interview with the Divisional Clinical Director on 03/25/22 at 3:51pm revealed: -The Care Coordinators were responsible for processing orders. -The order was sent to the pharmacy and when the medication was delivered to the facility, the order was approved in the eMAR, and the medication was to be administered per the order. -On 02/24/22 and 03/10/22, if the PCP stopped the medication, she expected the medication to be stopped immediately. -She was concerned the medication was not being administered correctly and the physicians' orders were not being followed in a timely manner. -She expected the RCC to have clarified the order from Resident #2's Neurologist's visit summary. -She was concerned Resident #2 was possibly being administered the incorrect dosage of	D 358		

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Depakote.

Interview with the Administrator on 03/25/22 at 3:51pm revealed:
-She expected medications to be administered as ordered and was concerned Resident #2's Depakote orders had not been followed.
-She expected the RCC to call and clarify Resident #2's Depakote order to make sure the resident was being administered the Depakote correctly since the note to continue the current dose was not actually what the resident was taking so staff could not continue it.

Attempted telephone interview with a second shift MA on 03/25/22 at 12:07pm was unsuccessful.

Refer to the telephone Interview with a pharmacy technician from the facility's contracted pharmacy on 03/24/22 at 8:36am.

Refer to the interview with the Special Care Coordinator (SCC) on 03/24/22 at 10:15am.

Refer to the interview with the Administrator on 03/28/22 at 9:29am.

3. Review of Resident #3's current FL-2 dated 02/10/22 revealed diagnoses included rheumatoid arthritis and partial traumatic amputation at lateral between knee and ankle of the right leg.

Review of Resident #3's physician's orders dated 02/10/22 revealed:
-There was an order for Lispro sliding scale insulin (SSI) (used to control blood sugar) as follows: 151-200=6 units, 201-250=10 units, 251-300=14 units, 301-350=18 units, and 350 or greater=18 units.

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-There was an order to call the primary care provider (PCP) if Resident #3's finger stick blood sugar (FSBS) was less than 60 or greater than 450.

Telephone interview with a pharmacy technician at the pharmacy's contracted pharmacy on 03/23/22 at 4:32pm revealed:
-Orders were entered into the electronic medication administration record (eMAR) system by the pharmacy and were approved by the facility staff.
-The facility staff could also enter orders and those orders would not need to be approved or denied by the pharmacy.
-The insurance had denied the Lispro insulin pen and a comparable formulary (Aspart) was approved by Resident #3's PCP on 03/09/22.
-The entry for Aspart was keyed into the eMAR system on 03/09/22 by the pharmacy staff.
-On 03/09/22, the staff at the facility reported the resident had Lispro on hand and the order for Aspart was not filled at that time.
-The Aspart insulin was requested to be filled on 03/13/22.
-The pharmacy was only able to add the order in and any additional lines required for documentation for the amount of insulin administered and the site would be the responsibility of the facility staff through the eMAR system.

Review of Resident #3's eMAR for March 2022 revealed:
-There was an entry for Lispro insulin pen 100 SSI administered before meals and at bedtime; 151-200=6 units, 201-250=10 units, 251-300=14 units, 301-350=18 units, and 350 or greater=18 units.
-There was documentation from

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03/01/22-03/12/22 at 7:30am, 12:00pm, 5:00pm, and 7:00pm of Resident #3's FSBS results, the number of units administered, and the site.
-There was documentation on 03/13/22 at 12:00pm, Resident #3's insulin was not administered with the reason documented as discontinued.
-There was documentation on 03/15/22 at 7:30am, Resident #3's FSBS results, the number of units administered, and the site.
-There was no documentation after 03/15/22 at 7:30am for the Lispro entry; each column dated through 03/25/22 had an "x" in place of an entry.
-There was an entry dated 03/13/22 for Aspart insulin pen U-100 SSI administered before meals and at bedtime; 151-200=6 units, 201-250=10 units, 251-300=14 units, 301-350=18 units, and 350 or greater=18 units with scheduled times of 7:30am, 11:30am, 5:00pm, and 8:00pm.
-There was only a space for documentation of the medication aide's (MA) initials with documentation beginning on 03/13/22 at 5:00pm.
-There was an entry for FSBS four times daily with scheduled times of 6:00am, 12:00pm, 5:00pm, and 7:00pm with a beginning entry of 03/18/22 at 5:00pm.
-There was documentation Resident #3's FSBS was checked 25 times from 03/18/22 at 5:00pm through 03/25/22 at 12:00pm.
-There were 22 of the 25 times Resident #3's FSBS was checked that SSI would need to be administered.
-There was no documentation Lispro or Aspart were administered for 22 out of 25 opportunities from 03/18/22 to 03/25/22.
-There was no space on the eMAR to document the amounts of insulin administered.
-There was no other documentation related to whether SSI was administered or the amount administered 22 times between

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03/18/22-03/25/22 when insulin was required per SSI order.

Review of Resident #3's vitals log on 03/25/22 revealed the resident's FSBS were recorded but there was no documentation of the amount of SSI that was administered.

Based on review of Resident #3's March 2022 eMARs, it could not be determined whether the resident's Lispro and/or Aspart insulin was administered as ordered per sliding scale.

Observation of Resident #3's medications on hand on 03/23/22 at 3:12pm revealed:
-There was an Aspart insulin pen on hand for SSI administration; the pen was opened on 03/18/22.
-There were no other Aspart or Lispro pens on hand.

Review of Resident #3's chart notes revealed:
-On 03/13/22, a MA documented calling the pharmacy at 11:54am about Resident #3's Aspart.
-On 03/13/22, the same MA documented talking to the pharmacy at 11:59am about Resident #3's Lispro being discontinued.
-On 03/13/22, the same MA documented talking to the pharmacy at 12:09pm, and Resident #3's Lispro had been discontinued and Aspart would be dispensed today, 03/13/22.

Telephone interview with the MA on 03/24/22 at 3:49pm revealed:
-She worked this past weekend (03/19/22).
-Resident #3 had an order for SSI.
-She did not recall if she had administered SSI for Resident #3 when she last worked.
-She recalled there was nowhere to document how much SSI was administered or the site.
-This was a new issue. She used to document

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Resident #3's FSBS in the eMAR, and the system displayed how many units of insulin needed to be administered based on the sliding scale.
-She did not recall if she had told anyone there was no place to document the SSI administered.
-There had been some confusion earlier in the month (March 2022) because when she was going to administer Resident #3's insulin, the Lispro had been discontinued and there was no order for the Aspart.
-She called the pharmacy to clarify and they were going to send the Aspart pen that day. (She did not recall the date).

Interview with Resident #3 on 03/23/22 at 3:50pm revealed:
-He was on an SSI.
-His FSBS was ordered to be checked four times a day, before breakfast, lunch, and dinner, and at bedtime.
-He did not know how much SSI was administered when he had his FSBS checked.
-He was administered SSI today, 03/23/22, at lunch because his FSBS was over 300.
-He did not know how much SSI was administered.
-He knew he missed a dose of his Lispro insulin a couple of weeks ago because there was some confusion with the order, but he only missed one dose that day.

Interview with Resident #3's PCP on 03/24/22 at 8:52am revealed:
-Resident #3 was admitted to the facility to recover from post amputation and healing and would return home once his amputation had healed.
-Resident #3's FSBS was a "disaster" and often ran high.
-She expected Resident #3's SSI to be

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administered as ordered.
-If Resident #3's SSI was not documented as administered, or the number of units given were not documented, then she could not be sure the resident's insulin had been administered or how many units were given.
-If Resident #3's SSI was not administered as ordered he would experience poor healing to his wounds due to his FSBS being uncontrolled.
-Resident #3 had to be referred to the wound clinic and receive home health for wound care because he had experienced poor healing.
-If Resident #3's FSBS was elevated and he did not receive SSI as ordered he could go into diabetic ketoacidosis [A serious diabetes complication where the body produces excess blood acids (ketones)] and would end up in the hospital.

Telephone interview with Resident #3's physician assistant (PA) at the wound clinic on 03/24/22 at 11:11am revealed:
-Resident #3 was being seen at the wound clinic with a goal to heal the resident's wounds so Resident #3 could use his prosthesis and return home.
-If a resident's FSBS was high and was not treated, it could slow down the healing process.

Interview with the RCC on 03/24/22 at 2:57pm revealed:
-Pharmacy staff entered orders in the eMAR and it was accepted by management at the facility.
-Resident #3's SSI order was confusing because it had been changed so much.
-Resident #3's FSBS was 280 at lunch today, 03/24/22, and he was administered 14 units of SSI.
-She read the directions in the eMAR and administered the SSI insulin, but she did not

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document the amount of insulin administered.
-If there was no place to enter the amount of insulin administered it would be documented on the vital log.
-There was usually somewhere to document the amount of SSI administered.
-Resident #3's order to check his FSBS and administer the SSI order dropped off the eMAR and she did not know why.
-She had emailed someone (she did not recall who or when) at corporate that the entry for FSBS, SSI, and the site had dropped off the eMAR.
-She documented when she administered SSI insulin.
-Staff would sometimes document the amount of insulin administered in the exceptions.
-She could not explain why there was no documentation in Resident #3's vital log or exceptions of the amount of SSI administered.

Interview with a MA on 03/25/22 at 10:42am revealed:
-Resident #3 was on a SSI.
-She looked at Resident #3's order on the eMAR to know how much SSI was to be administered.
-She documented how much SSI was administered and the site it was administered.
-When the FSBS results were entered, sometimes the amount to be administered "popped up" but sometimes the amount to be administered did not.
-If the amount to be administered did not "pop up" she would document the amount administered on Resident #3's vital log.
-She reported the issue to the RCC multiple times.
-If the amount of SSI was not documented staff would not know if the SSI was administered or not.

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D 358	Continued From page 52 Interview with the Divisional Clinical Director on 03/24/22 at 3:33pm revealed: -She had retrained all MAs on orders and medication administration on 01/24/22. -If a resident was on SSI, she expected the MAs to check the FSBS and administer insulin based on the sliding scale. -There should be an entry for Resident #3's FSBS and the amount of insulin administered in the eMAR. -If the amount of SSI administered was not documented, then it was considered as not done. -She would have expected the RCC to review the order for Resident #3's SSI and correct the eMAR to reflect the amount of insulin administered. Interview with the Administrator on 03/25/22 at 2:57pm revealed: -She expected Resident #3's SSI to have been documented if the SSI was administered. -If there was nowhere to document the SSI administered, she would have expected the MA to immediately tell the RCC and the RCC would fix the issue or call the eMAR system administrators to have the problem corrected. Attempted telephone interview with Resident #3's home health nurse on 03/24/22 at 10:45am was unsuccessful. Refer to the telephone interview with a pharmacy technician from the facility's contracted pharmacy on 03/24/22 at 8:36am. Refer to the interview with the Special Care Coordinator (SCC) on 03/24/22 at 10:15am. Refer to the interview with the Administrator on 03/28/22 at 9:29am.	D 358		

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4. Review of Resident #5's current FL-2 dated 01/27/22 revealed diagnoses included chronic obstructive pulmonary disease, seasonal allergies and vascular dementia.

a. Review of Resident #5's physician's orders dated 01/27/22 revealed an order for carbamazepine (used to treat mood swings) 200mg twice a day.

Review of Resident #5's February 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for carbamazepine 200mg with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation carbamazepine 200mg was administered twice a day from 02/01/22 to 02/28/22 at 8:00am and 8:00pm.

Review of Resident #5's March 2022 eMAR revealed:
-There was an entry for carbamazepine 200mg with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation carbamazepine 200mg was administered twice a day from 03/01/22 to 03/24/22 at 8:00am and 8:00pm.

Observation of Resident #5's medication on hand on 03/24/22 at 10:47am revealed:
-There was a bubble pack labeled carbamazepine 200mg with a dispense date of 01/24/22; there was 8 of 30 tablets remaining.
-There was a second bubble pack labeled carbamazepine 200mg with a dispense date of 1/24/22; there was 26 of 30 tablets remaining.
-There was a third bubble pack labeled carbamazepine 200mg with a dispense date of

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02/18/22; there were 30 of 30 tablets remaining.
-There was a fourth bubble pack labeled carbamazepine 200mg with a dispense date of 02/18/22; there were 30 of 30 tablets remaining.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 03/24/22 at 12:31pm revealed:
-There was an order for carbamazepine 200mg twice a day.
-The pharmacy dispensed 240 tablets of carbamazepine 200mg between 12/07/21 to 02/18/22.
-Sixty tablets of carbamazepine would last 30 days.

Based on eMAR documentation, medication dispensing records and medications on hand, there were 210 opportunities to administer Resident #5's carbamazepine 200mg twice a day as ordered; there were 94 tablets remaining for administration as of 03/23/22 when there should only be 30 tablets remaining.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 03/25/22 at 8:13am revealed:
-Carbamazepine was used to treat mood swings for people with dementia and to assist with controlling behavior and outburst.
-Resident #5 could have an increase in mood swings and behavioral disturbances if the medication was not administered as ordered.

Interview with the medication aide (MA) on 03/24/22 at 10:55am revealed:
-The pharmacy sent 4 bubble packs of medication, dated 01/24/22 and 2/18/22, at the same time.
-She did not know why the pharmacy sent

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February's medication in January and pre-dated the bubble packs.

Interview with the Special Care Coordinator (SCC) on 03/25/22 at 11:46am revealed:
-Resident #5 should not have extra medication on hand.
-The pharmacy sent enough medication for 30 days; the SCC would re-order the medication when the MAs pulled the re-order sticker and placed the sticker on the re-order form.
-It appeared Resident #5 was not being administered his medications as ordered.
-She expected the MAs to administer medications as ordered.

Interview with Resident #5's Primary Care Provider (PCP) on 03/28/22 at 12:46pm revealed:
-Carbamazepine was used to treat mood swings.
-Resident #5 could have an increase in mood swings if the medication was not administered as ordered.
-The PCP could increase the carbamazepine based on information provided by the staff regarding increase in mood swings, but the information provided would be incorrect because carbamazepine was not being administered as ordered.

Interview with the Administrator on 03/28/22 at 9:29am revealed:
-She did not know why there were so many carbamazepine tablets remaining for administration.
-The MAs should be administering medications as ordered.

Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable.

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D 358	Continued From page 56 b. Review of Resident #5's physician's orders dated 01/27/22 revealed an order for Trelegy Ellipta (used to prevent and control symptom of asthma) 100-62.5-25mcg inhale 1 puff daily. Review of Resident #5's February 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Trelegy Ellipta 100-62.5-25mcg with a scheduled administration time of 8:00am. -There was documentation Trelegy Ellipta was administered daily from 02/01/22 to 02/28/22 at 8:00am. Review of Resident #5's March 2022 eMAR revealed: -There was an entry for Trelegy Ellipta 100-62.5-25mcg with a scheduled administration time of 8:00am. -There was documentation Trelegy Ellipta was administered daily from 03/01/22 to 03/08/22 at 8:00am. -There was an electronic entry that Trelegy Ellipta was discontinued on 03/08/22. -There was a second entry for Trelegy Ellipta 100-62.5-25mcg with a scheduled administration time of 8:00am. -There was documentation Trelegy Ellipta was administered daily from 03/19/22 to 03/24/22 at 8:00am. Observation of Resident #5's medication on hand on 03/24/22 at 10:51am revealed: -There was a box labeled Trelegy Ellipta with a dispense date of 03/08/22; the box was sealed and unopened. -There was a second box labeled Trelegy Ellipta with a dispense date of 01/29/22; the box was	D 358		

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opened on 01/30/22.
-The second box contained a Trelegy Ellipta inhaler with 21 inhalations remaining.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 03/24/22 at 12:31pm revealed:
-The pharmacy had an order for Trelegy Ellipta inhale one puff daily with an order date of 01/30/22.
-The pharmacy dispensed three Trelegy Ellipta inhaler from 11/07/21 to 03/08/22.
-One Trelegy inhaler has 30 doses of medication in each inhaler.
-One Trelegy inhaler should last 30 days.

Based on eMAR documentation, medication dispensed and medications on hand, Resident #5 was not administered his Trelegy Ellipta for more than 51 times.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 03/25/22 at 8:13am revealed:
-Trelegy Ellipta was used for maintenance of chronic obstructive pulmonary disease (COPD) and asthma.
-Resident #5 could experience shortness of breath if the medication was not administered as ordered.

Interview with the medications aide (MA) on 03/24/22 at 10:55am revealed:
-She administered Trelegy Ellipta inhaler as ordered.
-She worked first shift when the medication was to be administered.
-She did not know why there were 21 inhalations remaining in an inhaler that was dated opened on 01/30/22 and only had 30 inhalations available for

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administration.

Interview with the Special Care Coordinator (SCC) on 03/25/22 at 11:46am revealed:
-Resident #5 should not have extra medication on hand.
-The pharmacy sent enough medication for 30 days and then the SCC would re-order the medication when the MAs pulled the re-order sticker and placed on the re-order form.
-It appeared that Resident #5 was not being administered his medications as ordered.
-The MAs should administer the medications as ordered.

Telephone interview with Resident #5's Primary Care Provider (PCP) on 03/28/22 at 12:46pm revealed:
-Trelegy Ellipta was a combination of medications used to treat COPD.
-Trelegy Ellipta was used as a preventive measure.
-Resident #5 could have an acute COPD flare up if his medications were not administered as ordered.

Telephone interview with the Administrator on 03/28/22 at 9:29am revealed:
-The Administrator expected Resident #5's Trelegy Ellipta to be administered daily as ordered.
-She did not know why there would be 21 inhalation doses of Trelegy Ellipta remaining in an inhaler that was dated as opened on 01/30/22.
-She expected the MAs to administer medications as ordered.

Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable.

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c. Review of Resident #5's physician's orders dated 01/27/22 revealed an order for rivastigmine (used to treat mood swings) 9.5mg/24hour transdermal patch apply one patch topically daily and remove old patch.

Review of Resident #5's February 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for rivastigmine 9.5mg/24hour transdermal patch with a scheduled administration time of 9:00am.
-There was documentation rivastigmine 9.5mg/24hour transdermal patch was administered from 02/01/22 to 02/28/22 at 9:00am.

Review of Resident #5's March 2022 eMAR revealed:
-There was an entry for rivastigmine 9.5mg/24hour transdermal patch with a scheduled administration time of 9:00am.
-There was documentation rivastigmine 9.5mg/24hour transdermal patch was administered from 03/01/22 to 03/24/22 at 9:00am.

Observation of Resident #5's medication on hand on 03/24/22 at 10:47am revealed there was a zip lock bag labeled rivastigmine 9.5mg/24hour patch with a dispense date of 12/25/21; there were 6 of 30 patches remaining.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 03/24/22 at 12:31pm revealed:
-The pharmacy had a physician's order for rivastigmine 9.5mg/24hour transdermal patch apply every morning and remove old patch.

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-The pharmacy dispensed 90 patches of rivastigmine 9.5mg/24hours from 08/21/21 to 12/25/21.
-The pharmacy had not dispensed rivastigmine 9.5mg/24hours patches since 12/25/21.
-The medication was dispensed when it was re-ordered by the facility staff.

Based on eMAR documentation, medication dispensing record and medications on hand, Resident # 5's rivastigmine 9.5mg patches was not administered 129 times.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 03/25/22 at 8:13am revealed:
-Rivastigmine 9.5mg/24hour transdermal patch was used to treat memory loss and cognitive abilities.
-Resident #5 could experience an increase of memory loss and faster decline in cognitive ability if the resident did not receive the medication as ordered.
-Resident #5 may have an increase in behavioral disturbances if not receiving the medication as ordered.

Interview with the medication aide (MA) on 03/24/22 at 10:55am revealed:
-The MA administered Resident #5's rivastigmine patch as ordered.
-When the new order of rivastigmine patches was delivered, another MA removed the patches from the zip lock bag with the most recent dispense date and placed the patches in the zip lock bag with the dispense date of 12/25/21.
-She did not know why the patches were moved from one zip lock bag to another.

Interview with the Special Care Coordinator

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(SCC) on 03/25/22 at 11:46am revealed:
-The SCC did not know why Resident #5's rivastigmine patches had not been ordered since 12/25/21.
-It did not appear Resident #5 received his rivastigmine patches as ordered.
-The pharmacy sent enough medication for 30 days and then the SCC would re-order the medication when the MAs pulled the re-order sticker and placed on the re-order form.
-It appeared Resident #5 was not being administered his medications as ordered.
-The MAs should administer the medications as ordered.

Telephone interview with Resident #5's Primary Care Provider (PCP) on 03/28/22 at 12:46pm revealed:
-Rivastigmine was used in residents with dementia to slow down memory loss and cognitive issues.
-Resident #5 may have an increase in cognitive behaviors and experience a rapid decline in his memory if not receiving the medication as ordered.

Telephone interview with the Administrator on 03/28/22 at 9:29am revealed:
-She expected Resident #5's transdermal patch to be placed topically every morning.
-She expected the MAs to administer medications as ordered.

Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable.

Refer to the telephone interview with a pharmacy technician from the facility's contracted pharmacy on 03/24/22 at 8:36am.

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Refer to the interview with the Special Care Coordinator (SCC) on 03/24/22 at 10:15am.

Refer to the interview with the Administrator on 03/28/22 at 9:29am.

5. Review of Resident #4's FL-2 dated 02/23/22 revealed diagnoses included dementia with behavioral disturbances, diabetes mellitus 2, hypertension, congestive heart failure and anxiety.

a. Review of Resident #4's physician's orders dated 02/23/22 revealed an order for folic acid (used as a vitamin supplement) 1mg daily.

Review of Resident #4's physician's orders dated 03/17/22 revealed an order to discontinue folic acid 1mg daily.

Review of Resident #4's March 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for folic acid 1mg daily with a scheduled administration time of 8:00am.
-There was documentation folic acid 1mg was administered daily from 03/03/22 to 03/20/22.
-There was an electronic entry to discontinue folic acid 1mg on 03/20/22.

Observation of Resident #4's medications on hand on 03/23/22 at 2:40pm revealed there was a multi-dose pack for the morning of 03/24/22 available; the multi-dose pack contained 1 folic acid 1 mg tablet.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 03/24/22 at 8:36am revealed:

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-The pharmacy had an FL-2 on file dated 02/23/22.
-The signed FL-2 had a signed order for folic acid 1mg daily.
-The folic acid had been dispensed in the multi-dose packs on 03/11/22, 03/18/22 and 03/25/22.
-The pharmacy had not received new orders dated 03/17/22 to discontinue folic acid 1mg.

Based on eMAR documentation, medication dispensing records and medications on hand it was determined that Resident' #5's folic acid 1mg was administered 7 times after it had been discontinued.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 03/25/22 at 8:13am revealed:
-Folic Acid was a supplement to treat anemia and deficiency of folic acid.
-A resident who received too much folic acid could develop kidney function problems.

Interview with the medication aide (MA) on 03/23/22 at 2:48pm revealed:
-When a medication was discontinued the Special Care Coordinator (SCC) would tell the MAs so they could mark if off the multi-dose pack.
-The MAs knew a medication was discontinued if the medication was marked off the multi-dose pack.
-The discontinued medication would be removed from the multi-dose pack and destroyed.
-She did not know the folic acid had been discontinued.
-She did not recall being notified that the folic acid was discontinued.
-She had not noticed that the folic acid was no

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longer on the eMAR.
-She did not remove the folic acid from the multi-dose pack and destroy the medication.
-She administered the folic acid because it was not marked off on the multi-dose pack.

Interview with the Special SCC on 03/24/22 at 10:15am revealed:
-She was responsible for sending the discontinued orders.
-She thought she had e-faxed the order to discontinue folic acid.
-The pharmacy should be discontinuing medications on the eMAR when the order was received.
-The SCC continually received phone calls from the facility's contracted pharmacy regarding received orders.

Telephone interview with the Primary Care Provider (PCP) on 03/24/22 at 9:20am revealed she expected the orders to be followed as written.

Telephone interview with the Administrator on 03/28/22 at 9:29am revealed:
-A medication that had been discontinued would not appear on the eMAR for administration.
-The MA should realize there was an extra medication in the multi-dose pack, remove it and destroy it.
-The MAs were not comparing medications to the eMARs prior to administration of medications.

b. Review of Resident #4's physician's orders dated 02/23/22 revealed an order for thiamine-B1 (used as a vitamin supplement) 100mg daily.

Review of Resident #4's physician's orders dated 03/17/22 revealed an order to discontinue thiamine-B1 100mg daily.

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Review of Resident #4's March 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for thiamine-B1 100mg daily with a scheduled administration time of 8:00am.
-There was documentation thiamine was administered daily from 03/03/22 to 03/07/22 at 8:00am
-There was an electronic entry to discontinue thiamine-B1 100mg on 03/07/22.
-There was a second entry for thiamine-B1 100mg daily with a scheduled administration time of 8:00am.
-There was documentation thiamine was administered daily from 03/08/22 to 03/20/22 at 8:00am.
-There was an electronic entry to discontinue thiamine-B1 100mg on 03/20/22.

Observation of Resident #4's medications on hand on 03/23/22 at 2:40pm revealed there was a multi-dose pack for the morning of 03/24/22 available; the multi-dose pack contained 1 thiamine-B-1 100mg tablet for administration.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 03/24/22 at 8:36am revealed:
-The pharmacy had an FL-2 on file dated 02/23/22.
-The signed FL-2 had a signed order for thiamine-B1 100mg daily.
-The pharmacy had not received new orders dated 03/17/22 to discontinue thiamine-B1.

Based on eMAR documentation, medication dispensing records, medications on hand and interviews it was determined Resident #4 was administered thiamine-B-1 7 times after the

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medication had been discontinued.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 03/25/22 at 8:13am revealed:
-Thiamine-B1 100mg was a supplement to treat vitamin B deficiencies.
-A resident who received too much thiamine-B1 could develop kidney function problems.

Interview with the medication aide (MA) on 03/23/22 at 2:48pm revealed:
-When a medication was discontinued the Special Care Coordinator (SCC) would tell the MAs so we could mark if off the multi-dose pack.
-The MAs knew a medication was discontinued if the medication was marked off the multi-dose pack.
-The discontinued medication would be removed from the multi-dose pack and destroyed.
-She did not know the thiamine-B-1 100mg had been discontinued.
-She did not recall being notified that the thiamine-B-1 100mg was discontinued.
-She MA had not noticed that the thiamine-B-1 100mg was no longer on the eMAR.
-She did not remove the thiamine-B-1 100mg from the multi-dose pack and destroy the medication.
-She administered the thiamine-B-1 100mg because it was not marked off on the multi-dose pack.

Interview with the SCC on 03/24/22 at 10:15am revealed:
-She was responsible for sending the discontinued orders.
-She thought she had e-faxed the order to discontinue folic acid.
-The pharmacy should be discontinuing

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medications on the eMAR when the order was received.
-The SCC continually received phone calls from the facility's contracted pharmacy regarding received orders.

-Telephone interview with the Primary Care Provider (PCP) on 03/24/22 at 9:20am revealed she expected the orders to be followed as written.

Telephone interview with the Administrator on 03/28/22 at 9:29am revealed:
-A medication that had been discontinued would not appear on the eMAR for administration.
-The MA should realize there was an extra medication in the multi-dose pack, remove it and destroy it.
-The MAs were not comparing medications to the eMARs prior to administration of medications.

Refer to the telephone interview with a pharmacy technician from the facility's contracted pharmacy on 03/24/22 at 8:36am.

Refer to the interview with the Special Care Coordinator (SCC) on 03/24/22 at 10:15am.

Refer to the interview with the Administrator on 03/28/22 at 9:29am.

6. Review of Resident #8's FL 2 dated 01/18/22 revealed diagnoses included unspecified dementia essential hypertension.

a. Review of Resident #8's FL 2 dated 01/18/22 revealed an order for Senexon-S (used to treat constipation) 8.6-50mg twice a day.

Review of Resident #8's February 2022 electronic medication administration record (eMAR)

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D 358	Continued From page 68 revealed; -There was an entry for Senexon-S 8.6-50mg with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Senexon-S 8.6-50mg was administered twice a day from 02/01/22 to 02/28/22 at 8:00am and 8:00pm. Review of Resident #8's March 2022 eMAR revealed: -There was an entry for Senexon-S 8.6-50mg with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Senexon-S 8.6-50mg was administered twice a day from 03/01/22 to 03/23/22 at 8:00am and 8:00pm and on 03/24/22 at 8:00am. Observation of Resident #8's medications on hand on 03/24/22 at 2:37pm revealed there was no Senexon-S 8.6-50mg available for administration. Interview with the medication aide (MA) on 03/25/22 at 11:00am revealed: -Resident #8 gave out of Senexon-S on Tuesday, 03/22/22. -Resident #8 did not receive his medications from the facility's contracted pharmacy. -The MA was told on Thursday, 03/24/22, that the medication would arrive that night. -The MA documented the medication was administered on 03/23/22 and 03/24/22 by mistake. Interview with the Special Care Coordinator (SCC) on 03/25/22 at 11:15am revealed: -Resident #8 did not have Senexon-S to administer for 2 weeks. -Resident #8 did not use the facility's contracted	D 358		

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pharmacy.
-She administered medication on the morning and evening of 03/20/22 and the evening of 03/23/22 in the SCU.
-She did not realize that she had documented on 03/20/22 at 8:00am and 8:00pm and on 03/23/22 at 8:00pm that she administered Senexon-S to Resident #8.
-She knew the medication had not arrived from the pharmacy.
-She should have documented an exception on the eMAR that the medication was not available for administration.

Telephone interview with Resident #8's Primary Care Provider (PCP) on 03/28/22 at 12:46pm revealed:
-Senexon-S was used for constipation.
-Resident #8 was ordered Senexon-S because of constipation.
-If Resident #8 was not receiving Senexon-S as ordered, it could lead to constipation and abdominal discomfort.
-The PCP expected medications to be administered as ordered.

Interview with the Administrator on 03/28/22 at 11:13am revealed:
-The MAs should document accurately on the eMAR.
-The eMAR should reflect medication was not available for administration.

Attempted telephone interview with Resident #8's representative from the pharmacy on 03/25/22 at 3:30pm was unsuccessful.

Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable.

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b. Review of Resident #8's physician's order dated 02/09/22 revealed an order for acetaminophen (used to treat pain) 325mg three tablets three times a day.

Review of Resident #8's February 2022 electronic medication administration record (eMAR) revealed;
-There was an entry for acetaminophen 325mg, three tablets three times a day with a scheduled administration time of 8:00am, 12:00pm and 8:00pm.
-There was documentation acetaminophen 325mg was administered three times a day from 02/09/22 to 02/1/22; on 02/12/22 at 8:00am; on 02/14/22 at 12:00pm and 8:00pm and 02/15/22 to 02/28/22 at 8:00am, 12:00pm and 8:00pm.
-There were exceptions documented on 02/08/22 at 8:00pm; on 02/12/22 at 12:00pm and 8:00pm; on 02/14/22 at 8:00am; the exception was pharmacy.
-There were exceptions documented on 02/13/22 at 8:00am, 12:00pm and 8:00pm; the exception was medication will be sent Monday.

Review of Resident #8's March 2022 eMAR revealed:
-There was an entry for acetaminophen 325mg, three tablets three times a day with a scheduled administration time of 8:00am, 12:00pm and 8:00pm.
-There was documentation acetaminophen 325mg was administered three times a day at 8:00am, 12:00pm and 8:00pm.

Observation of Resident #8's medications on hand on 03/24/22 at 2:37pm revealed:
-There was 1 bottle with a pharmacy label attached that read "acetaminophen 325mg take 3

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D 358	Continued From page 71 tablets 3 times a day". -The dispense date on the medication bottle was 02/12/22. -The prescription label on the medication bottle stated 2 of 2 bottles. -According to the pharmacy label, each bottle contained 150 acetaminophen tablets for a total of 300 acetaminophen tablets dispensed on 02/12/22. -There was only one bottle of acetaminophen 325mg available for dispensing. -The one remaining bottle contained 145 of 150 tablets. Based on eMAR documentation, medication prescription labels and medications on hand, Resident # 8's acetaminophen would not be administered or administered correctly 129 times from 02/12/22 to 03/24/22. Interview with the medication aide (MA) on 03/25/22 at 11:00am revealed: -She only administered one Tylenol tablet three times a day. -She read the administration instructions incorrectly. -If she had administered acetaminophen as ordered, there would not be extra acetaminophen remaining. Interview with the Special Care Coordinator (SCC) on 03/25/22 at 11:15am revealed: -The MAs should administer the medication as ordered. -The MAs should be careful when reading the order and check it three times as they were taught. Telephone interview with Resident #8's Primary Care Provider (PCP) on 03/28/22 at 12:46pm	D 358		

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revealed:
-Resident #8 received acetaminophen for arthritic discomfort.
-Resident #8 could have an increase in pain if he was not being administered acetaminophen as ordered.
-The PCP expected medications to be administered as ordered.

Interview with the Administrator on 03/28/22 at 9:29am revealed:
-The Administrator expected Resident #8's acetaminophen to be administered as ordered.
-She expected the MAs to administer medications as ordered.

Attempted telephone interview with a representative from Resident #8's pharmacy on 03/25/22 at 3:30pm was unsuccessful

Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable.

c. Review of Resident #8's physician's order dated 03/17/22 revealed an order for divalproex (used to treat acute manic symptoms) 125mg twice a day.

Review of Resident #8's March 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for divalproex 125mg twice a day with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation divalproex 125mg was administered on 03/22/22 at 8:00pm; on 03/23/22 at 8:00am and 8:00pm; and on 03/24/22 at 8:00am.
-There was an exception documented on

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03/24/22 at 8:00pm; the exception was medication unavailable, waiting on pharmacy.

Observation of Resident #8's medications on hand on 03/24/22 at 2:37pm revealed there was no divalproex 125mg available for administration.

Interview with the medication aide (MA) on 03/25/22 at 11:00am revealed:
-She called the facility's contracted pharmacy to send the medication.
-She was told on Thursday, 03/24/22 that the medication would arrive that night.
-She documented the medication was administered on 03/23/22 and 03/24/22 at 8:00am by mistake.

Interview with the SCC on 03/25/22 at 11:15am revealed:
-She administered medication on the evening of 03/23/22.
-She did not realize that she had documented on 03/23/22 at 8:00pm that she administered divalproex 125mg to Resident #8.
-She knew the medication had not arrived from the pharmacy.
-She should have documented an exception on the eMAR that the medication was not available for administration.

Interview with Resident #8's Primary Care Provider (PCP) on 03/28/22 at 12:46pm revealed:
-Divalproex 125mg was ordered as a mood stabilizer.
-Resident #8 was ordered divalproex 125mg because of increased agitation.
-The facility staff complained of Resident #8 hitting other residents and being aggressive toward staff.
-Resident #8 did not receive his medications from

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the facility's contracted pharmacy and had not received the medication from his pharmacy.
-The facility asked the PCP on 03/24/22 to e-fax an order to the facility's contracted pharmacy.
-The PCP did not know that the staff had been documenting that it was administered twice a day since 03/22/22 at 8:00pm.
-Documentation of a medication given when it was not given could alter further medication ordered based on lab results.
-The PCP expected medications to be administered as ordered.

Interview with the Administrator on 03/28/22 at 11:13am revealed:
-The MAs should administer medications as ordered.
-The eMAR should reflect medication was not available for administration.

Attempted telephone interview with a representative from Resident #8's pharmacy on 03/25/22 at 3:30pm was unsuccessful.

Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable.

Refer to the telephone interview with a pharmacy technician from the facility's contracted pharmacy on 03/24/22 at 8:36am.

Refer to the interview with the Special Care Coordinator (SCC) on 03/24/22 at 10:15am.

Refer to the interview with the Administrator on 03/28/22 at 9:29am.

7. Review of Resident #6's FL 2 dated 02/21/22 revealed diagnoses included Alzheimer's disease

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and dementia.

a. Review of Resident #6's FL 2 dated 02/21/22 revealed an order for venlafaxine ER (used to treat depression) 75mg twice a day.

Review of Resident #6's physician's orders dated 03/07/22 revealed:
-There was an order to discontinue venlafaxine ER 75mg twice a day.
-There was an order for venlafaxine ER 75mg daily.

Review of Resident #6's March 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for venlafaxine ER 75mg with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation venlafaxine ER 75mg was administered twice a day from 03/01/22 to 03/24/22.

Observation of Resident #6's medications on hand on 03/23/22 at 10:15am revealed:
-There was a multi-dose pack containing venlafaxine ER 75mg available for administration in the 8:00am and 8:00pm dose packs.
-Venlafaxine ER 75 mg was 1 of 7 pills in the 8:00am multi-dose pack and 1 of 3 pills in the 8:00pm multi-dose pack.
-The instruction for administration on the multi-dose pack read "one capsule twice a day".

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 03/24/22 at 8:36am revealed:
-The pharmacy had an order for venlafaxine ER 75mg twice a day dated 07/30/21.
-The pharmacy dispensed weekly multi-dose

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packs for Resident #6 every Thursday.
-The pharmacy did not receive a signed physician's order dated 03/07/22 to decrease venlafaxine ER 75 mg from twice a day to daily.
-The facility sent new orders by e-fax; the physician sent new orders by e-script.
-New ordered medications would be sent the same day or next day, depending on what time the new order was received.
-The medication could be delayed if the pharmacy was waiting for insurance approval.

Based on eMAR documentation, medication dispensing records and interviews it was determined that venlafaxine ER 75mg was administered 32 times after the medication had been changed to daily administration.

Interview with the medication aide (MA) on 03/24/22 at 10:18am revealed:
-The MA administered venlafaxine ER 75mg twice a day because it was on the eMAR to administer.
-The MA did not know the venlafaxine ER 75mg had been changed from twice a day to daily
-The MA was not responsible for discontinuing or adding medications on the eMAR.
-The Special Care Coordinator (SCC) was responsible for e-faxing new or changed orders to the pharmacy.
-The pharmacy would enter the new orders into the eMAR and the change would appear on the eMAR.
-The MA had no way of knowing the venlafaxine ER 75mg order had changed unless it was entered and on the eMAR.

Interview with second a MA on 03/24/22 at 4:10pm revealed:
-Venlafaxine ER 75mg was entered on the eMAR

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to administer twice a day.
-The MA documented she had administered venlafaxine ER 75mg 4 times at 8:00pm since 03/07/22.
-The MA did not know Resident #6 had an order dated 03/07/22 to change venlafaxine ER 75mg from twice a daily
-The MA administered the medication as directed on the eMAR.
-Venlafaxine ER 75mg was available in the multi-dose pack to administer twice a day.
-The MA would not know a medication had changed unless it was entered on the eMAR.
-The SCC e-faxed new orders to the pharmacy.
-The pharmacy would enter changes to the medications on the eMAR.

Interview with the SCC on 03/24/22 at 10:15am revealed:
-She e-faxed new orders to the pharmacy when they were written.
-She would call the pharmacy to verify they received the e-faxed orders, when scheduling permitted.
-She had e-faxed the physician's orders dated 03/07/22 to the pharmacy.
-She could not remember the first time she e-faxed the physician's order dated 03/07/22, but she e-faxed it again today, 03/24/22, because the pharmacy staff called and said they did not have it.
-She did not call the pharmacy today, 03/24/22, to see if they had received the e-faxed physician's order dated 03/07/22 for Resident #6.
-The pharmacy should enter the order into eMAR when it was received.
-She could not remember if she informed the MA about the change in order and to make a notation on Resident #6's multi-dose pack.

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D 358	Continued From page 78 Telephone interview with a nurse at Resident #6's Primary Care Provider's office (PCP) on 03/26/22 at 11:42am revealed: -Resident #6 was receiving venlafaxine ER for mood swings. -The PCP expected all orders to be followed as ordered. Telephone interview with the Administrator on 03/28/22 at 9:29am revealed: -New orders should be faxed to the facility's contracted pharmacy. -The SCC was responsible for faxing new orders to the facility's contracted pharmacy. -The Administrator did not know why the order had not been faxed to the facility's contracted pharmacy. -She expected new orders to be faxed to the facility's contracted pharmacy when the order was received. -The residents were not getting their medications as ordered. -The facility staff was not following protocol when ordering medications. b. Review of Resident #6's FL 2 dated 02/21/22 revealed an order for omeprazole (used to treat gastric reflux) 40mg twice a day. Review of Resident #6's physician's orders dated 03/07/22 revealed: -There was an order to discontinue omeprazole 40mg twice a day. -There was an order for omeprazole 40mg daily. Review of Resident #6's March 2022 electronic medication administration record (eMAR) revealed: -There was an entry for omeprazole 40mg with a scheduled administration time of 8:00am and	D 358		

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8:00pm.
-There was documentation omeprazole 40mg was administered twice a day from 03/01/22 to 03/24/22.

Observation of Resident #6's medications on hand on 03/23/22 at 10:15am revealed:
-There was a bubble pack containing 8 capsules of omeprazole 40mg available for administration.
-The instruction for administration on the pharmacy label read "one capsule twice a day".

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 03/24/22 at 8:36am revealed:
-The pharmacy had an order for omeprazole twice a day dated 07/30/21.
-The pharmacy did not receive a signed physician's order dated 03/07/22 to decrease omeprazole 40mg from twice a day to daily.
-The facility sent new orders by e-fax; the physician sent new orders by e-script.
-New ordered medications would be sent the same day or next day, depending on what time the new order was received.
-The medication could be delayed if the pharmacy was waiting for insurance approval.

Based on eMAR documentation, medication dispensing records and interviews, it was determined that omeprazole was administered 32 times after the medication had been changed to daily.

Telephone interview with the Pharmacist on 03/24/22 at 8:13am revealed:
-Omeprazole was used to treat gastric reflux.
-A resident could have abdominal pain, gastrointestinal discomfort, nausea and vomiting if they received too much omeprazole.

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Interview with the MA on 03/24/22 at 10:18am revealed;
-The MA administered omeprazole 40mg twice a day because it was on the eMAR to administer.
-The MA did not know the omeprazole 40mg had been changed from twice a day to daily
-The MA was not responsible for discontinuing or adding medications on the eMAR.
-The Special Care Coordinator (SCC) was responsible for e-faxing new or changed orders to the pharmacy.
-The pharmacy would enter the new orders into the eMAR and the change would appear on the eMAR.
-The MA had no way of knowing the omeprazole 40mg order had changed unless it was entered and on the eMAR.

Interview with second a MA on 03/24/22 at 4:10pm revealed:
-Omeprazole 40mg was entered on the eMAR to administer twice a day.
-The MA documented she had administered omeprazole 40mg 4 times at 8:00pm from 03/07/22 to 03/24/22.
-The MA did not know Resident #6 had an order dated 03/07/22 to change omeprazole 40mg from twice a daily
-She administered the medication as directed on the eMAR.
-Omeprazole 40mg was available in a bubble pack to administer twice a day.
-She would not know a medication had changed unless it was entered on the eMAR.
-The SCC e-faxed new orders to the pharmacy.
-The pharmacy would enter changes to the medications on the eMAR.

Interview with the SCC on 03/24/22 at 10:15am

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revealed:
-She e-faxed new orders to the pharmacy when they were written.
-She would call the pharmacy to verify they received the e-faxed orders, when scheduling permitted.
-She had e-faxed the physician's orders dated 03/07/22 to the pharmacy.
-She could not remember the first time she e-faxed the physician's order dated 03/07/22, but she e-faxed it again today, 03/24/22, because they called and said they did not have it.
-She did not call the pharmacy today, 03/24/22, to see if they had received the e-faxed physician's order dated 03/07/22 for Resident #6.
-The pharmacy should enter the order into eMAR when it was received.
-She could not remember if she informed the MA about the change in order and to make a notation on Resident #6's multi-dose pack

Telephone interview with a nurse at Resident #6's Primary Care Provider's (PCP) office on 03/26/22 at 11:42am revealed:
-Resident #6 was receiving omeprazole for gastric reflux and heart burn.
-The PCP expected all orders to be followed as ordered.

Telephone interview with the Administrator on 03/28/22 at 9:29am revealed:
-New orders should be faxed to the pharmacy.
-The SCC was responsible for faxing new orders to the facility's contracted pharmacy.
-She did not know if this order had been faxed to the facility's contracted pharmacy.
-She expected new orders to be faxed to the facility's contracted pharmacy.
-The facility's contracted pharmacy would enter the new orders into the eMAR.

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Refer to the telephone interview with a pharmacy technician from the facility's contracted pharmacy on 03/24/22 at 8:36am.

Refer to the interview with the Special Care Coordinator (SCC) on 03/24/22 at 10:15am.

Refer to the interview with the Administrator on 03/28/22 at 9:29am.

____

Interview with the Special Care Coordinator (SCC) on 03/24/22 at 10:15am revealed:
-The medication aides (MA) completed medication cart audits weekly.
-The MAs audit consisted of ensuring medications were on hand matched the eMAR, open dates were documented on medication bottles and boxes, and all medications were available for administration.
-The MAs should be using the most recently signed physician's orders when auditing.
-The SCC tried to assign a different MA to audit the medication cart each week.
-The MAs should be reporting any concerns to the SCC after the audits were completed.
-The SCC had received no concerns from the audits in two months.

Interview with the Administrator on 03/28/22 at 9:29am revealed:
-The MA should administer medications as ordered.
-New orders should be on the eMAR within 24 hours unless there was a concern with payment or the medication was not available in the pharmacy.
-The SCC and Resident Care Coordinator (RCC) audited the medication carts three times a week.
-The SCC and RCC assigned a MA to audit the

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D 358	Continued From page 83 medication carts weekly. -The facility staff should look for discontinued medications and medications that needed to be re-ordered and compare the medications on hand with the medications listed on the eMAR. ______________________ The facility failed to ensure medications were administered as ordered for 2 residents observed during the medication pass including a resident (#6) who was administered an as needed pain medication when it was not requested and a resident (#7) who was administered a medication for dementia in the morning instead of as scheduled in the evening; and for 4 sampled residents for record review including a resident (#3) who was admitted to the facility for treatment of wounds following an amputation of the lower extremity and who was ordered sliding scale insulin (SSI) that was not documented as administered on 22 occasions when his fingerstick blood sugar required SSI to be administered, resulting in being unable to determine the amount of insulin, if any, was administered putting the resident at risk for elevated blood sugars with no SSI converage and possibly interfering with wound healling; and a resident (#2), who had a history of seizures and changes were made to increase his depakote dosage, which was not implemented for 4 days and on another occasion, his depakote dosage was decreased and the resident received an additional dosage for 7 days, resulting in the provider being unable to titrate the resident's depakote appropriately, putting the resident at risk for seizures or depakote toxicity. This failure resulted in substantial risk of harm to the residents, which constitutes a Type A2 Violation. ______________________________ The facility provided a plan of protection in	D 358		

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D 358	Continued From page 84 accordance with G.S. 131D-34 on 03/24/22 for this violation. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 27, 2022.	D 358		
D 363	10A NCAC 13F .1004(f) Medication Administration 10A NCAC 13F .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with	D 363		

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the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure medications prepared for administration in advance were kept in a sealed container that identified the name and strength of each medication prepared, identified up to the point of administration, and protected from contamination and spillage for 4 of 4 residents (#1, #6, # 8, #9) during the 8:00am medication pass on 03/23/22.

The findings are:

Observation of the Special Care Unit (SCU) medication cart on 03/24/22 at 8:07am revealed:
-There were 4 plastic medication cups in the top drawer of the medication cart; each containing medication.
-Three of four medication cups held multiple pills; the fourth cup help 1 capsule.
-The medications were not sealed; the medication cups did not have a covering.
-The medication cups were not labeled with the names of residents or medications.

1. Review of Resident #1's current FL2 dated 03/02/22 revealed diagnoses included unspecified anemia, diabetes mellitus type 2, back pain, other skin changes, bipolar disorder, chronic obstructive pulmonary disease, non-Hodgkin lymphoma, and essential hypertension.

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Observation of a medication cup on 03/23/22 at 8:06am revealed:
-There were 10 pills in the unlabeled medication cup.
-There was 1 square, beige tablet; 1 round, green tablet; 5 round, white tablets; 1 round, peach tablet; 1 white, oblong tablet; and 1 red, oblong tablet.

Interview with the MA on 03/23/22 at 10:18am revealed:
-She identified the red, oblong pill by comparing the pill with Resident #1's bubble pack containing daily-vite.
-The red, oblong pill in the cup was identified as Resident #1's daily-vite 100mg.
-She identified the round, peach pill by comparing the pill with Resident #1's bubble pack containing lisinopril 10mg.
-The round, peach pill in the cup was identified as Resident #1's lisinopril 100mg.

2. Review of Resident # 6's current FL2 dated 02/21/22 revealed diagnoses included Alzheimer's disease and dementia.
Observation of a second medication cup on 03/23/22 at 8:07am revealed there was 1 brown and blue capsule in the unlabeled medication cup.

Interview with the MA on 03/23/22 at 10:18am revealed:
-She identified the brown and blue capsule comparing the pill with Resident #6's bubble pack containing omeprazole 10mg
-The brown and blue capsule in the cup was identified as Resident #6's omeprazole.

3. Review of Resident #8's current FL2 dated 01/18/22 revealed diagnoses included

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unspecified dementia and essential hypertension.

Observation of a third medication cup on 03/23/22 at 8:07am revealed:
-There were 2 pills in the unlabeled medication cup.
-There was 1 round, white tablet, and 1 green and yellow capsule.

Interview with the MA on 03/23/22 at 10:18am revealed:
-She identified the round, white pill by comparing the pill with Resident #8's medication bottle containing acetaminophen.
-The round white pill in the cup was identified as Resident #8's acetaminophen.
-She identified the green and yellow capsule by comparing the capsule with Resident #8's medication bottle containing tamsulosin.
-The green and yellow capsule was identified as Resident #8's tamsulosin.

4. Review of Resident #9's current FL-2 dated 01/25/22 revealed diagnoses included essential hypertension, Alzheimer's disease, anxiety disorder, and unspecified dementia with behavioral disturbances.
Observation of a fourth medication cup on 03/23/22 at 8:08am revealed:
-There were 5.5 pills in the unlabeled medication cup.
-There were 2 round, white tablets; 1 round, pink tablet; 1 round, peach tablet; 1 round, dark peach tablet; and ½ of a round, white tablet.

Interview with the MA on 03/23/22 at 10:18am revealed:
-She identified the round, pink pill by comparing the pill with the picture on Resident #9's multi-dose pack containing vitamin B-12.

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D 363	Continued From page 88 -The round, pink pill in the cup was identified as Resident #9's vitamin B-12. -She identified the round, peach pill by comparing the pill with the picture on Resident #9's multi-dose pack containing furosemide 20mg. -The round, peach pill in the cup was identified as Resident #9's furosemide 20mg. -She identified the round, dark peach pill by comparing the pill with the picture on Resident #9's multi-dose pack containing aspirin 81mg. -The round, dark peach pill in the cup was identified as Resident #9's aspirin 81mg. -She identified one and 1/2 round white pills by comparing the pill with the picture on Resident #9's multi-dose pack containing escitalopram 10mg. -The round, white pill and ½ pill in the cup were identified as Resident #9's escitalopram 10mg. -She identified the second, round white pill by comparing the pill with the picture on Resident #9's multi-dose pack containing buspirone 5mg. -The second, round, white pill in the cup was identified as Resident #9's buspirone 5mg. ______________ Interview with the MA on 03/23/22 at 10:18am revealed: -She usually did not prepare medications in advance. -She was late starting her 8:00am medication pass this morning. -She thought preparing medications in advance would help her get all the medication administered in the ordered time frame. Interview with the SCC on 03/24/22 at 10:15am revealed: -Medications should not be prepared in advance for administration and stored on the medication cart. -All medications should be administered after	D 363		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 363	Continued From page 89 prepping for administration. -The medication could be administered to the incorrect resident if prepped in advance, unlabeled, and stored on the medication cart. -The facility did not have a policy for preparing medications in advance. Interview with the Administrator on 03/28/22 at 9:29am revealed: -The facility followed the state rules in the preparation of medications in advance for administration. -Medications should not be prepared in advance unless a resident was leaving the facility. -Once a medication was prepared, it should be administered to the resident. -The Administrator expected medication to be administered immediately after being prepared. -The Administrator was concerned medications could be administered to the wrong resident.	D 363		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of	D 367		

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medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to ensure the electronic medication administration records were accurate for 2 of 7 sampled residents (#7, #8) including inaccurate documentation of a cholinesterase inhibitor (#7); and inaccurate documentation an anti-convulsant used for bipolar (#8).

The findings are:

1. Review of Resident #7's FL-2 dated 03/15/22 revealed:
-Diagnoses included dementia with Lewy body, visual hallucinations, fatigue, insomnia, and anxiety disorder.
-There was an order for donepezil (used to slow down memory loss and improve cognitive function) 10mg at bedtime.

Review of Resident #7's March 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for donepezil 10mg one every evening before bed; the electronic entry was discontinued on 03/16/22.
-There was documentation donepezil 10mg was administered at 8:00pm from 03/01/22 to 03/15/22
-There was an entry for donepezil 10mg one every evening before bed.

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D 367	Continued From page 91 -There was documentation donepezil 10mg was administered at 5:00pm from 03/16/22 to 03/22/22. Observation of Resident #7's medications on hand on 03/23/22 at 10:50am revealed there was a morning multi-dose pack available for administration; the morning multi-dose pack contained 1 donepezil 10mg. Telephone Interview with a pharmacy technician from the facility's contracted pharmacy on 03/24/22 at 8:36am revealed donepezil 10mg tablet was packed in the morning multi-dose pack since 07/31/21. Interview of the medication aide (MA) on 03/24/22 at 10:18am revealed: -She would compare medications in the multi-dose pack with the eMAR, administer the medications and sign off on the eMAR. -She did not notice the donepezil was in the morning dose pack and was scheduled for administration on the eMAR for 8:00pm. -She did not sign off that she gave the donepezil at the morning medication pass; she did not realize she had not signed that donepezil was administered at 8:00am. Interview with the Special Care Coordinator (SCC) on 03/24/22 at 11:05am revealed: -The MAs should compare the medications in the multi-dose pack with the eMAR. -The MAs should administer medications as scheduled and document on the eMAR. -The MAs should notify the SCC and the pharmacy of any discrepancies with dispensing of medications and entries on the eMAR. Telephone interview with the Administrator on	D 367		

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03/28/22 at 9:29am revealed:
-The MAs should compare the medication being administered to the eMAR.
-If the MAs were comparing medications as they were taught, the donepezil would not have been administered in the morning and documented as administered in the evening.
-The first shift MA should have noticed donepezil was in the morning multi-dose pack and called the pharmacy to have it placed in the evening dose pack.

Based on observations, interviews, and record reviews it was determined Resident #7 was not interviewable.

Attempted to interview Resident #7's Primary Care Provider (PCP) on 03/25/22 at 3:00pm was unsuccessful.

2. Review of Resident #8's FL-2 dated 01/18/22 revealed diagnoses included unspecified dementia and essential hypertension.

Review of Resident #8's physician's order dated 03/17/22 revealed an order for divalproex 125mg (used to treat acute manic symptoms) 125mg twice a day.

Review of Resident #8's March 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for divalproex 125mg with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation divalproex 125mg was administered on 03/22/22 at 8:00pm; on 03/23/22 at 8:00am and 8:00pm; and on 03/24/22 at 8:00am.
-There was an exception documented on

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D 367	Continued From page 93 03/24/22 at 8:00pm; the exception was the medication was unavailable for administration. Interview of the medication aide (MA) on 03/25/22 at 10:15am revealed: -She had documented the administration of divalproex 125mg by mistake. -The medication was delivered last night, 03/24/22, on third shift. -Resident #8 received his first dose of divalproex 125mg this am, 03/25/22 at 8:00am. Interview with the Special Care Coordinator (SCC) on 03/25/22 at 11:15am revealed: -She worked as the MA on second shift in the SCU on 03/23/22. -She documented on the eMAR that she administered divalproex 125mg at 8:00pm. -She did not administer divalproex 125mg at 8:00pm; the medication had not been delivered to the facility by the pharmacy. -She should have documented an exception because divalproex was not available for administration. Interview with the Primary Care Provider (PCP) on 03/25/22 at 10:18am revealed: -She ordered divalproex 125mg twice a day on 03/17/22 for Resident #8. -She was informed yesterday, 03/24/22, the medication had not been delivered from Resident #8's pharmacy. -She e-faxed a prescription to the facility's contracted pharmacy so the medication could be started without any further delay. -She was not aware the MAs had been documenting that the medication was being administered since 03/22/22. -Documenting a medication was administered when it was not available for administration could	D 367		

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D 367	Continued From page 94 alter the way she wrote further orders. Telephone interview with the Administrator on 03/28/22 at 9:29am revealed: -The MAs should be comparing compare the medication being administered to the eMAR. -If the medication was not available for administration the MA should document an exception instead of documenting the medication was administered. -The eMARs should display an accurate description of the medications the residents receive. Based on observations, interviews, and record reviews it was determined Resident #7 was not interviewable.	D 367		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility.	D 612		

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This Rule is not met as evidenced by:
Based on record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection to the residents during the global coronavirus (COVID-19) pandemic as related to the screening of residents and the use of facemasks by staff.

The findings are:

1. Review of the CDC Interim Infection Prevention and Control Recommendations to prevent SARs-CoV-2 spread in Nursing Homes dated 02/22/22 revealed residents should be evaluated daily for symptoms of COVID-19 and actively monitor residents for fever.

Review of five residents' March 2022 electronic medication administration records (eMARs) revealed there was no documentation of temperature checks since 03/16/22.

Interview with a medication aide (MA) on 03/23/22 at 10:27am revealed:
-The staff just recently stopped taking the resident's temperatures.
-She did not know why the orders were removed from the eMAR to check resident's temperatures daily.

Interview with a second MA on 03/25/22 at 3:10pm revealed:
-There was an entry on the eMAR for the resident's temperature readings to be obtained daily.
-The entry for daily temperature readings was no

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longer on the eMAR; it had not been on the eMAR in 2 weeks.
-She did not know why the resident's temperature checks fell off the eMAR.
-She had not screened in a while; she could not remember the last time she screened before entering the building.
-She would check her temperature daily, but she did not document her reading.

Telephone interview with a third MA on 03/28/22 at 11:24am revealed:
-The resident's temperatures are not checked at this time.
-The order to check resident's temperatures were no longer on the eMAR.
-The resident's temperatures have not been checked in a couple of weeks.
-He did not know why temperature readings were no longer being obtained.

Interview with 5 residents on 03/25/22 from 2:47pm to 3:43pm revealed:
-One resident's temperature had not been checked in two months.
-Another resident could not recall the last time her temperature was checked.
-A third resident would have her temperature checked every two weeks.
-A fourth resident could not remember the last time his temperature was checked.
-A fifth resident had her temperature checked daily until a couple of weeks ago; she did not know why they stopped checking her temperature every day.

Interview with the SCC on 03/25/22 at 2:50pm revealed:
-Resident's temperatures were not being taken daily.

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-The facility received an email from corporate on 03/16/22.
-The email stated that since there had been a decrease in COVID cases within the facilities it had been decided to stop resident's daily screening.
-The entry for resident's daily screening including daily temperature checks was discontinued from the eMAR on 03/16/22.
-She did not know who discontinued the screening on the eMAR.

Telephone interview with the Administrator on 03/28/22 at 11:13am revealed:
-The Administrator was not sure if residents' daily temperatures were being taken and documented.
-The facility staff should be checking residents' daily temperatures.
-She expected the facility staff to check resident's temperatures daily.
-She did not know why the staff had stopped checking residents' temperatures.
-She was not sure what the CDC guidelines stated at this time.
-She was not sure what the company policy was related to temperature checks but thought the daily temperature checks may have stopped a few weeks ago.

2. Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the COVID-19 Pandemic updated 02/02/22 revealed:
-Source control measures were to be implemented for HCP.
-Source control referred to the use of well-fitting facemasks to cover a person's mouth and nose to prevent the spread of respiratory secretions when the person was breathing, talking, sneezing, or coughing.

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D 612	Continued From page 98 -Fully vaccinated HCP should wear source control when they were in areas of the facility where they could encounter residents. Review of the NC DHHS COVID-19 Infection Prevention Guidance for Long-Term Care Facilities dated 02/10/22 revealed cloth masks were not considered personal protective equipment (PPE) and should not be worn by staff. Review of the facility's COVID-19 policy date 01/04/2022 revealed: -The policy was titled the community employee COVID-19 vaccination, testing and face covering policy. -Employees who were not fully vaccinated against COVID-19 would be required to wear acceptable face coverings. -Acceptable face coverings must completely cover the nose and mouth. -Exceptions to wearing a face mask included when an employee was alone in a room with floor to ceiling walls and a closed door, or while the employee was eating or drinking. Observation of the facility's front door on 03/25/22 at 7:49am revealed signage stating face mask required prior to entry. Observation of a personal care aide (PCA) on 03/23/22 at 8:00am revealed: -The PCA opened the Special Care Unit (SCU) door to allow the surveyor to enter; the PCA was not wearing a mask. -The PCA continued to serve breakfast trays to residents in the SCU dining room prior to donning a mask. Telephone interview with a PCA on 03/28/22 at 11:24am revealed:	D 612		

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-He was not wearing a mask on Wednesday morning, 03/23/22 at 8:00am
-He had worked third shift and had prepared to leave when he was asked to stay over and help with breakfast.
-He would take his mask off before leaving the SCU.
-He walked to the back of the building to clock out, walked through the dining room and exited the building through the front door when leaving the facility without a mask.
-The Special Care Coordinator (SCC) and the Resident Care Coordinator (RCC) would not say anything to the staff about wearing a mask.
-The Administrator would speak to the staff if they were not wearing a mask or not wearing the mask correctly.
-The surgical mask should cover the nose and mouth when wearing it correctly.

Observation of a medication aide (MA) on 03/23/22 at 8:01am revealed:
-She was standing at the medication cart preparing medications for administration.
-The medication cart was in the hallway next to the opened dining room.
-The MA was not wearing a mask while preparing medications for administration.
-The MA retrieved and donned a mask from the desk when surveyor entered the SCU.

Interview with a MA on 03/25/22 at 3:10pm revealed:
-She wore a mask when she was providing resident care.
-She would pull the mask down below her chin when she was by herself.
-She forgot to put a mask on Wednesday morning, 03/25/22, when she came to work.
-Mask were made available to the staff; they were

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D 612	Continued From page 100 located at the nurse's station. -She would enter the back of the building and clock in and walk to the SCU to retrieve and don a mask. -The correct way to wear a surgical mask was to cover the mouth and nose. Observation of the same MA on 03/23/22 at 8:31am revealed her mask was under her chin with mouth and nose exposed. Observation of dietary staff on 08/23/22 at 8:04am revealed: -She was in the kitchen prepping breakfast meal. -Her mask was under her chin; her mouth and nose were exposed. Observation of the nurse's station on 03/23/22 at 8:10am revealed there was a box of 50 surgical mask on the desk available to the staff. Observation of a second MA on 03/23/22 at 8:20am with her mask under her chin with mouth and nose exposed. Observation of the second MA on 03/23/22 at 9:46am to 9:53am revealed her mask was under her chin with mouth and nose exposed. Observation of a maintenance personal on 03/23/22 at 8:44am revealed his mask was under his chin with his mouth and nose exposed. Observation of the housekeeper on 03/23/22 at 8:50am revealed her mask was under her chin with mouth and nose exposed. Observation of a PCA on 03/23/22 between 12:35pm to 12:41pm revealed she pulled her mask down below her chin twice to speak to	D 612		

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another staff member while feeding a resident in the SCU dining room

Observation of a second PCA on 03/25/22 at 3:45pm revealed she was wearing a cloth mask while working in the SCU.

Interview with the second PCA on 03/25/22 at 3:45pm revealed:
-Today was the first day she had worn a cloth mask.
-She had not been told she could not wear a cloth mask.
-She knew there were surgical masks provided by the facility.
Observation of the housekeeper on 03/23/22 at 8:50am revealed her mask was under her chin with mouth and nose exposed.

Observation of a PCA on 03/23/22 between 12:35pm to 12:41pm revealed she pulled her mask down below her chin twice to speak to another staff member while feeding a resident in the SCU DR.

Observation of a second PCA on 03/25/22 at 3:45pm revealed she was wearing a cloth mask while working in the SCU.

Interview with 5 residents on 03/25/22 from 2:47pm to 3:43pm revealed:
-Most staff wore their mask most of the time.
-She saw some of the staff wearing mask but not all.
-Not every staff wore a mask.
-Sometimes the staff wore their mask below their chin.
-Some staff wore mask and some do not.
-She did not know if the staff were to wear mask or not.

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Interview with a MA on 03/25/22 at 3:10pm revealed:
-She wore a mask when she was providing resident care.
-She would pull the mask down below her chin when she was by herself.
-She forgot to get a mask on Wednesday morning, 03/25/22, when she came to work.
-Mask were made available to the staff; they were located at the nurse's station.
-She would enter the back of the building and clock in and walk to the SCU to retrieve and don a mask.
-She had not screened in a while; she could not remember the last time she screened before entering the building.
-She would check her temperature daily, but she did not document her reading.
-The correct way to wear a surgical mask was to cover the mouth and nose.

Interview with the second PCA on 03/25/22 at 3:45pm revealed:
-Today was the first day she had worn a cloth mask.
-She had not been told she could not wear a cloth mask.
-She knew there were surgical mask provided by the facility.

Interview with 5 residents on 03/25/22 from 2:47pm to 3:43pm revealed:
-One resident saw staff wear their mask most of the time.
-Another resident saw some of the staff wearing mask but not all.
-A third resident did not see every staff wear a mask.
-A fourth resident saw staff wear their mask

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: ______ B. WING ______	R 04/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	**2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 612	Continued From page 103 below their chin. -A fifth resident saw some staff wear a mask but not all staff; she did not know if the staff were to wear mask or not. Interview with the SCC on 03/25/22 at 2:50pm revealed: -Mask should be worn by staff daily; the mask should cover their mouth and nose. -Staff could remove their mask while eating and when in an office alone. -She tried to remind the staff to wear their mask and wear them correctly. -She was not aware of the current CDC guidelines. Telephone interview with the Administrator on 03/28/22 at 11:13am revealed: -The facility staff should wear a surgical mask in the facility, except when eating. -The surgical mask should cover the nose and mouth when worn correctly. -She instructed staff to place the surgical mask over their nose and mouth when she saw it worn incorrectly. -She did not know that employees were not wearing mask. -There was an increased chance in spreading germs and viruses if the mask were not worn when in the facility. -The staff was not following policy if they were not wearing their mask when in the facility	D 612		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: ______ B. WING ______	R 04/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D912	Continued From page 104 relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to medication administration. The findings are: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 7 residents (#6, #7) observed during the morning medication pass including errors with the administration of a pain medication (#6) and a medication for memory loss (#7); and for 5 of 7 sampled residents for record review including errors with a medication used to prevent seizures (#2); insulin administration (#3); an inhaler, an antimanic medication, and a topical patch used for dementia (#5); three supplements (#4); an anti-depressant and a medication for reflux (#6); and a stool softener, a pain medication and a medication used to treat manic episodes (#8). [Refer to Tag D 0358, 10A NCAC 13 F .1004(a) Medication Administration (Type A2 Violation)]	D912		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
HAL001148 (Y1)	A. Building B. Wing (Y2)	4/12/2022 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix D0137 Reg. # 10A NCAC 13F .0407(a)(5) LSC	Correction Completed 03/10/2022	ID Prefix D0375 Reg. # 10A NCAC 13F .1005(a) LSC	Correction Completed 03/10/2022	ID Prefix D0377 Reg. # 10A NCAC 13F .1006(a) LSC	Correction Completed 03/10/2022
ID Prefix D932 Reg. # G.S. 131D-4.4A (b) LSC	Correction Completed 03/10/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
10/4/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO